

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1187

CERTIFICATE OF DEATH

Reg. Dist. No.

01179

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 10+ YRS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL — SHARPSBURG					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hosp. Sal		d. STREET ADDRESS ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JOSEPH		First	Middle NEHEMIAH	Last ABBOTT	4. DATE OF DEATH JAN. 18 1958	Month JAN.	Day 18	Year 1958	
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 19, 1882	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER.		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) VIRGINIA, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME SINNET NEHEMIAH ABBOTT		14. MOTHER'S MAIDEN NAME ELIZABETH FRANCES GROVE		Address PETER SIMEON ABBOTT BOONS BORO ROUTE 1					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X		DUE TO LOBULAR PNEUMONIA		INTERVAL BETWEEN ONSET AND DEATH 6 DYS.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO PULMONARY EMBOLI & INFARCTS		UNKNOWN					
(c)		ARTERIOSCLEROTIC & HYPERTENSIVE CARDIOVASCULARS		7 YRS					
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) AORTIC & MITRAL VALVULITIS — RHEUMATIC — HEALED.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) JAN. 18, 1958		(County) 1958	(State) 1958
21. I certify that I attended the deceased from NOV. 11, 1957 to JAN. 18, 1958 , that I last saw the deceased alive on JAN. 18, 1958 , and that death occurred at JAN. 18, 1958 , from the causes and on the date stated above. ACTUAL SIGNATURE George Berce, M.D.		ADDRESS (Street, city or town, state) WESTERN MARYLAND STATE HOSPITAL		DATE SIGNED 1958					
22a. BURIAL, CREMATION, REMOVE <input type="checkbox"/> (Specify) Burial Jan. 24, 1958		22b. DATE THEREOF Jan. 24, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Hagerstown Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md		ADDRESS Albert Leaf Williamsport, Md		24a. REC'D BY REGISTRAR JAN 22 '58		24b. REGISTRAR'S SIGNATURE Albert Leaf			

WISCONSIN STATE GOVERNMENT DEPARTMENT OF DEFENSE - MILITARY

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
JAN 22 1968

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01180

1188

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 10 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BOONSBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS SOUTH MAIN STREET	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle S	Last ASHBAUGH
4. DATE OF DEATH	Month JANUARY	Day 18	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 21 1891
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) ROHRERSVILLE WASH.CO.MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JACOB BOYER	
14. MOTHER'S MAIDEN NAME ELIZABETH McBRIDE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT GEORGE E. ASHBAUGH Jr. BOONSBORO MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X DUE TO Hodgkin's Disease		INTERVAL BETWEEN ONSET AND DEATH 12 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260 Diabetic Mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 15, 1958 , to Jan 18, 1958 , that I last saw the deceased alive on Jan 18, 1958 , and that death occurred at 1029 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Edward W. Ditto III M.D. 217 W. Washington Street DATE SIGNED 1/20/58			
ACTUAL SIGNATURE Edward W. Ditto III			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF JANUARY 21 1958	22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY	22d. LOCATION (City, town, or county) (State) BOONSBORO WASH.CO.MD.
23. FUNERAL DIRECTOR'S SIGNATURE Pauline Gloue Boonsboro Md.		24a. REC'D BY REGISTRAR JAN 22 '58	24b. REGISTRAR'S SIGNATURE Audrey

D-1. Ditto III
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

87. ДРОНЛАД – МЕДИА-ПОЛУМОСТАНОВЩИКИ ДИЗАЙНА

JAN 22 1953

RECEIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 01181	
Item 9 Film G224 1-15-58 et											
1239 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAN MAR					c. LENGTH OF STAY IN 1b 7 years					b. COUNTY WEST VIRGINIA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHRNEY KEEDY MEMORIAL HOME					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) NEW CREEK					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
g. STREET ADDRESS 85X-3											
3. NAME OF DECEASED (Type or print)		First LAURA	Middle	Lost	4. DATE OF DEATH		Month JANUARY	Day 7-19	Year 1958		
5. SEX		6. COLOR OR RACE FEMALE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DECEMBER 31 1869	9. AGE (In years lost birthday) 88 889 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW CREEK W EST VIRGINIA U.S.A.		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME MILTON BAKER		14. MOTHER'S MAIDEN NAME PHADELIA WILT									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RECORDS FAHRNEY KEEDY HOME BOONSBORO MD.R		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 10 yrs					
		DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Descompensation of heart				1 cwk.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Baltimore	(State) Md.		
21. I certify that I attended the deceased from Sept 1, 1957 to Jan 7, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at Baltimore , from the causes and on the date stated above.											
ACTUAL SIGNATURE G. White Van. ADDRESS (Street, city or town, state) Baltimore DATE SIGNED 1-7-58											
PHYSICIAN'S NAME (Type) G. White Van.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 10, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Bakers Cemetery		22d. LOCATION (City, town, or county) Gaithersburg, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Roger Fuell Home		ADDRESS Kingsport, Tenn.		24a. REC'D BY REGISTRAR JAN 10 '58		24b. REGISTRAR'S SIGNATURE Abigail					

CERTIFICATE OF DEATH

Date of Birth

Name of Deceased

Cause of Death

Date of Death

Place of Death

Name
of
Deceased

Name of Hospital

Name of Doctor

Name of Mortician

Name of Coroner

Name of Sheriff

Name of Clerk

Name of Sheriff's Office

BUREAU V. S.

JAN 10 1978

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01182

1189 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 10 days				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Ohmer			First Clayton	Middle Beachley	4. DATE OF DEATH January		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1884	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 9 Days 5	IF UNDER 24 HRS. Hours 5 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Fairplay, Maryland			
13. FATHER'S NAME Charles E. Beachley			14. MOTHER'S MAIDEN NAME Laura Huntzberry				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 219-14-8295 A		17. INFORMANT Mrs. Esther Beachley			
						Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident						INTERVAL BETWEEN ONSET AND DEATH 7 days	
33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.			(b) cerebral arteriosclerosis and hypertensive cardiovascular disease			2 yrs. 9 mos.	
DUE TO			(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cystitis, pyelitis ---duration 8 days						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Maryland	(State)
21. I certify that I attended the deceased from January 3, 1958 , to January 13 1958 , that I last saw the deceased alive on January 12, 1958 , and that death occurred at 6:50A M , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. T. Layman</i> M.D. 100 Professional Arts Bldg. 1/13/58							
ADDRESS (Street, city or town, state) Hagerstown, Maryland							
DATE SIGNED 1/13/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/1958		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 15 '58	24b. REGISTRAR'S SIGNATURE <i>Albert esch</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

BUREAU V. S.

JAN 15 1963

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 01183	
1190 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY WASHINGTON					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN					c. LENGTH OF STAY IN 1b LIFE					b. COUNTY WASHINGTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 134 ELIZABETH ST.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle EDWARD	Last BLENARD	4. DATE OF DEATH JANUARY 28 1958	Month JANUARY	Day 28	Year 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2/14/1889	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOILER MAKER			10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME CHRISTIAN BLENDAR			14. MOTHER'S MAIDEN NAME SUSAN BESECKER								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-6819	17. INFORMANT MRS. MARY E. BLENDAR	Address HAGERSTOWN MD.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO 199.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Phlebothromboli 2t leg DUE TO (c) Carcinoma liver of abdomen DUE TO										INTERVAL BETWEEN ONSET AND DEATH 15 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov. 28, 1957 , to 28 Jan. 1958 , that I last saw the deceased alive on 28 Jan. 1958 , and that death occurred at 12:30 AM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Oldlands Boarding 115 W. Wash. St. Hagerstown, Md.	DATE SIGNED 52/12/58
ACTUAL SIGNATURE Eldred Hoachlander											
PHYSICIAN'S NAME (Type) Eldred Hoachlander											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/30/58	22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.								
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.					ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 31 '58	24b. REGISTRAR'S SIGNATURE Archaeus				

MARYLAND STATE DEPARTMENT OF HABITAT-BALTIMORE TA

CERTIFICATE OF DEATH

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BUREAU V.

JAN 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1191

CERTIFICATE OF DEATH

01184
302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 128 High St	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle NMN	Last BRILLHART	4. DATE OF DEATH Jany 14 1958	Month Year 19	Day	Year
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug 27 1875	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Porter Chem Co		11. BIRTHPLACE (State & foreign country) Pennsyl Co Boiling Springs Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Brillhart				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 317-18-8997		17. INFORMANT Mrs Sarah Wiley 128 High St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) Arterio-sclerotic heart disease 2 yrs + cerebral thrombosis							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign prostatic hypertrophy							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 10, 1956 , to Jan 14, 1958 . That I last saw the deceased alive on Jan 14, 1958 , and that death occurred at 9 1/2 M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Edward W. Ditto, M.D. 217 W. Washington Street DATE SIGNED 1/14/58							
ACTUAL SIGNATURE Edward W. Ditto							
PHYSICIAN'S NAME (Type) Edward W. Ditto M.D. Hagerstown, Maryland							
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/16/58		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Andrew K. Coffman Hagerstown Md.							
24a. REC'D BY REGISTRAR JAN 16 1958 24b. REGISTRAR'S SIGNATURE DATE 1/16/58							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
BUREAU V. S.

JAN 1923

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1240

CERTIFICATE OF DEATH

Reg. Dist No 1185

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BEAVER CREEK RURAL				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAGERSTOWN MD. R. 1		d. STREET ADDRESS HAGERSTOWN MD. R. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HARRY		First	Middle	Lost	4. DATE OF DEATH JANUARY 30 1958	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 17 1900	9. AGE (in years lost birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROAD SUPERVISOR WASH. CO. ROAD DEPT.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BEAVER CREEK WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME WILLIAM BRINING		14. MOTHER'S MAIDEN NAME KATIE RUDY		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) NO		16. SOCIAL SECURITY NO. 314-09-3596		17. INFORMANT MRS. ILEIDA BRINING HAGERSTOWN MD. R. 1		INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Arteriosclerotic Heart Disease 6 yrs						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 12-1-1957 , to 1-30-1958 , that I last saw the deceased alive on 1-29-58 , and that death occurred at 3 PM , M, from the causes and on the date stated above. ACTUAL SIGNATURE K. E. RUDY						ADDRESS (Street, city or town, state) Hagerstown		DATE SIGNED 1/30/58
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEBRUARY 2 1958		22c. NAME OF CEMETERY OR CREMATORIUM MT. LENA CEMETERY		22d. LOCATION (City, town, or county) MT. LENA WASH. CO. MD.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Barry Funeral Home Boonsboro Md		ADDRESS Boonsboro Md		24a. REC'D BY REGISTRAR DATE 1/30/58		24b. REGISTRAR'S SIGNATURE Barry Funeral Home		

AMERICAN STATEMENT OF CHARGE - FEBRUARY 18

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 5 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File G224 1-8-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

011186
563

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 7 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMA		First FRANCES	Middle BURGAN
4. DATE OF DEATH Jany 1 1958	Month 1958	Day 1958	Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1881
9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? Vanderbilt Fayette Co USA	
13. FATHER'S NAME Irvin Grimm		14. MOTHER'S MAIDEN NAME Mary E. Hilling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Theodore E. Burgan 330 So Main St		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Cachexia - debility - collapse DUE TO (c) Lymphoma			
INTERVAL BETWEEN ONSET AND DEATH 5 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension Arterio vascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1956	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 31, 1956 to 1/1/58 , 19, that I last saw the deceased alive on 1/1/58 , 19, and that death occurred at Hagerstown , Md., from the causes and on the date stated above. ACTUAL SIGNATURE Louis G. Gratt PHYSICIAN'S NAME (Type) Louis G. Gratt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery
22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		24a. RECD BY REGISTRAR JAN 1 1958	24b. REGISTRAR'S SIGNATURE A. Wiedrich

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V.

JAN 6 1953

RECEIVED

FOR STATE
HEALTH DEPT.

Page
4 should be forwarded to the Chief Medical Examiner's Office along with farm DAS. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1193 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01187

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 36 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 20 Garlinger Ave.				d. STREET ADDRESS 20 Garlinger Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NOAH		First	Middle	Last	4. DATE OF DEATH Month Jan.	Day 24	Year 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH Dec. 16, 1892	9. AGE (In years last birthday) 65	yr. 65	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Luray, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Thomas Lee Burker		14. MOTHER'S MAIDEN NAME Jennie Breedon									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-05-6730		17. INFORMANT Mr. Geo Burker 318 Linganore Ave. Hagerstown, Md		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Cervical Vertebrae						INTERVAL BETWEEN ONSET AND DEATH					
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 900.0		(b)									
DUE TO Fractured Cervical Vertebrae		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Tuberculosis of Lung						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Apparently fell downstair-steps at home while going to bathroom									
20c. TIME OF INJURY Month, Day, Year Hour o. m. Jan. 24 1958		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) at home		20f. (City or town) (County) (State) Hagerstown Wash Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 1-24 '58					
EXAMINER'S NAME (Type) S. Robert Wells, M.D.											
22a. BURIAL, CREMATION OR REMOVAL (Specify) Burial		22b. DATE THEREOF 1/27/58		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR DAN 2 8 '58		24b. REGISTRAR'S SIGNATURE Alv. French					

BUREAU K 5

JAN 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01188

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1		Items 18 & 21 Film 220 2-24-58 a.m.s										Reg. Dist. No.							
1194																			
1. PLACE OF DEATH a. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Hagerstown Maryland		6 Days		a. STATE		Maryland		b. COUNTY		Washington							
c. LENGTH OF STAY IN lb						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Washington County Hospital				X Hancock													
e. STREET ADDRESS		218 Maryland Ave.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month		Day		Year					
Virginia		Elizabeth		Burnett				1		25		19		58					
5. SEX		6. COLOR OR RACE		7. MARRIED		NEVER MARRIED		8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.					
F		W		WIDOWED		DIVORCED		8.25.1922		35 yrs.		8 Months		Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?													
Housewife		Housewife		Morgan County W.VA.		U.S.A.													
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME																	
Lorne Bohrer		Leona Bohrer																	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address													
No				Charles R Burnett		Hancock Maryland.													
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cellulitis & septicemia (undiagnosed organism) <i>900.0 Undetermined Yet</i>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)		DUE TO secondary to laceration of rt knee															
		(c)		DUE TO Terminal hemorrhagic esophagitis															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell while going up icy steps to home</i>																	
20c. TIME OF INJURY Month, Day, Year Hour		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
11:10 a.m. Jan. 15 1958				Home		Hancock Wash Md													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .																			
ACTUAL SIGNATURE		<i>S. Robert Wells</i>										DATE SIGNED							
EXAMINER'S NAME (Type)		S. Robert Wells, M.D.										Jan. 28 '58							
M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>																			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>																			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)													
Burial		1.29.58		Union Chapel		Berkeley Springs W. V. A.													
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS										24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<i>Howard P. Stover Hancock Md.</i>												DATE JAN 31 '58		<i>Abelsoeck</i>					

STATE DEPARTMENT OF LABOR - ALASKA
EXAMINER'S CERTIFICATE OF DEATH

BUREAU Y. S.

JAN 31 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01189

1241

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural		c. LENGTH OF STAY IN lb life				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.F.D. # 4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) David Howard Carr		First David	Middle Howard			
4. DATE OF DEATH 1 12 19 58	Last Carr	Month 1	Day 12	Year 19 58		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH April 24, 1957	9. AGE (in years last birthday) yrs. 8		
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>			IF UNDER 1 YEAR Months 8	IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant	10b. KIND OF BUSINESS OR INDUSTRY infant	11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jay B. Carr		14. MOTHER'S MAIDEN NAME Mary K. Howard				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Jay Carr	Address Hagerstown R 4		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus (sudden death) DUE TO 543X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						
INTERVAL BETWEEN ONSET AND DEATH						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none				
20c. TIME OF INJURY Hour o. m. p. m. none	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) -	(County) -	(State) -
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED 1-13-58
EXAMINER'S NAME (Type) S. Robert Wells, M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 1-14-58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown Md.		ADDRESS 2081378XV6	24a. REC'D BY REGISTRAR DAWAN 15 '58		24b. REGISTRAR'S SIGNATURE <i>Officel</i>	

JAN 15 1968

MEGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01190

Reg. Dist. No.

1195

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 10 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 626 Salem Ave.,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 626 Salem Ave.,						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Louis Godfred Castang		First	Middle	Last	4. DATE OF DEATH Month 1 Day 11 Year 1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 2-5-1883		9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY farmer		11. BIRTHPLACE (State or foreign country) Atwood, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis Castang			14. MOTHER'S MAIDEN NAME Emma Wilson				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. I 353-18-5264		17. INFORMANT Mrs. Olive R. Castang		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary thrombosis INTERVAL BETWEEN ONSET AND DEATH DUE TO Diabetes M 2 days							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
None							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) — — —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>S. Robert Wells</i>		DATE SIGNED 1-13-58					
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.				ADDRESS			
24a. RECEIVED BY REGISTRAR JAN 15 1958				24b. REGISTRAR'S SIGNATURE <i>John E. Schuch</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

JAN 15 1968

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01191

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the State Board of Health.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 40 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 137 N. Jonathan St		d. STREET ADDRESS 137 N. Jonathan St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Daniel	Middle Clark	4. DATE OF DEATH Jan. 5 Month Day Year 19 58
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891 9. AGE (In years (at birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Comfort Station	11. BIRTHPLACE (State or foreign country) Berryville, Virginia
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War #1	17. INFORMANT Reese Jackson Winchester Va.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		420 Kent Street	
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Arteriosclerotic myocardial heart disease with myocardial failure grade iv 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH, none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) -		(County) -	
(State) -			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) S. Robert Wells	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-7-58
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Jan. 7, 1958	22c. NAME OF CEMETERY OR CREMATORIUM National Cemetery	22d. LOCATION (City, town, or county) Winchester, Va. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md.	ADDRESS JAN 9 '58	24a. REC'D BY REGISTRAR JAN 9 '58	24b. REGISTRAR'S SIGNATURE Albert E. Edwards

BUREAU V. S.

JAN 9 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1197

CERTIFICATE OF DEATH

Reg. Dist. No.

01192

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 52 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 753 W. Washington St.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
3. NAME OF DECEASED (Type or print)		First H	Middle Zelene		
		Lost Clark	4. DATE OF DEATH Month 1 Day 3 Year 1958		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1883		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home	11. BIRTHPLACE (State or foreign country) Wilson District, Md.		
13. FATHER'S NAME John B. Huyett		14. MOTHER'S MAIDEN NAME Mary E. Downin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT David E. Clark Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 3, 1958 , to Jan 3, 1958 , that I last saw the deceased alive on Jan 3, 1958 , and that death occurred at 214 N. Potomac St. M.D. from the causes and on the date stated above. ACTUAL SIGNATURE Lloyd A. Hoffmeyer ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Lloyd A. Hoffmeyer Hagerstown, Md. DATE SIGNED 1/6/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-6-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill	22d. LOCATION (City, town, or county) Hagerstown (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE JAN 8 '58	24b. REGISTRAR'S SIGNATURE Albert Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REGISTRATION NO.	NAME	SEX	AGE	DEATH DATE	TIME	CAUSE OF DEATH	DEATH CERTIFIED BY
1234567890	JOHN D. DOUGLASS	M	52	1958	12:00 P.M.	HEART DISEASE	DR. JAMES H. HARRIS
ADDRESS							
123 FAIRFIELD DR., GREEN BAY, WISCONSIN 54301							
CITY, STATE, ZIP CODE							
GREEN BAY, WISCONSIN 54301							
PHONE NUMBER							
414-446-1234							
MATERIAL TESTED							
BLOOD							
TESTS							
HISTOLOGICAL EXAMINATION							
EXAMINER							
DR. JAMES H. HARRIS							
SIGNATURE							
JAN 8 1958							

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1242

CERTIFICATE OF DEATH

Reg. Dist. No.

01193

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Route 1		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Route 1 Clear Spring, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Residence		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) HARRY		First Middle Lost		4. DATE OF DEATH January		Month Day Year 4 1958		
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 11, 1876	9. AGE (In years lost birthday) 81 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer		10b. KIND OF BUSINESS OR INDUSTRY Laborer		11. BIRTHPLACE (State or foreign country) Washington County		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Cunningham				14. MOTHER'S MAIDEN NAME Susan Brash				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-8862		17. INFORMANT Mrs Viola Angle		Address Route 1 Clear Spring, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 Chronic Endocarditis Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arterial Sclerosis				INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 10 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Oct 11, 1957 , to Jan 4, 1958 , that I last saw the deceased alive on Jan 4, 1958 , and that death occurred at 421 M., from the causes and on the date stated above.								
ACTUAL SIGNATURE David R. Brewer		ADDRESS (Street, city or town, state) Clear Spring Md						DATE SIGNED 1/6/58
PHYSICIAN'S NAME (Type) David R. Brewer								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 7, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		22d. LOCATION (City, town, or county) Washington		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Clark		ADDRESS Clear Spring, Md.		24a. REC'D BY REGISTRAR JAN 8 '58		24b. REGISTRAR'S SIGNATURE Dee Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.

JAN 8 1958

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1198

CERTIFICATE OF DEATH

Dr Packer

01194

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 12 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2221 Virginia Ave		d. STREET ADDRESS 2221 Virginia Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First Vernon	Middle Blain	Last Dellinger	4. DATE OF DEATH Jan 22 1958
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 14, 1884	9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months 73	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Near Downsville Md	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	--	--

13. FATHER'S NAME Jacob Dellinger	14. MOTHER'S MAIDEN NAME Laura Snyder
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Sarah Grace Dellinger	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH 15 minutes
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.	Cerebral hemorrhage
DUE TO (b) Hypertension arteriosclerosis DUE TO (c) Varicose Vein	Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 22, 1957 , to May 21, 1958 , that I last saw the deceased alive on May 22, 1957 , and that death occurred at 11:45 AM , from the causes and on the date stated above.			
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ACTUAL SIGNATURE <i>L. L. Packer</i>	M.D. 145 W. Washington St. 1/22/58	ADDRESS (Street, city or town, state) Hagerstown, Md.	DATE SIGNED 1/22/58
PHYSICIAN'S NAME (Type) L. L. Packer Dr.			

22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan 24/58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cem.	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
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23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman	ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE JAN 28 '58	24b. REGISTRAR'S SIGNATURE DeWitt
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U. S. GOVERNMENT PRINTING OFFICE 1938
CERTIFICATE OF DEATH

BUREAU V. S.

JAN 28 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Hornbaker

CERTIFICATE OF DEATH

Reg. Dist. No. 01195

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. STREET ADDRESS / 341 East Irvin Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HANNAH	First BELL	Middle DIETRICH	Last
4. DATE OF DEATH January 20, 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12, 1878
9. AGE (In years less birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Mother	10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Md. Burkettsville, Fred. Co.	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Amos Brandenberg	14. MOTHER'S MAIDEN NAME Alice Lakin		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No (Yes, No, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 230-30-9891	17. INFORMANT Mrs. Charlotte Stone-341 E. Irvin Av.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 1 wk - 16 years?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? carbure thrombosis YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-25-1941, to 1-20-1958, that I last saw the deceased alive on 1-20-1958, and that death occurred at 6:20 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE John H. Hornbaker		ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md.	
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		DATE SIGNED 1:20:58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-23-58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman* Hagerstown, Maryland		24a. REC'D BY REGISTRAR JAN 22 '58	24b. REGISTRAR'S SIGNATURE W.L. esch
		DATE	

BUREAU Y. S.

JAN 22 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1243

CERTIFICATE OF DEATH

Reg. Dist. No.

01196

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Md. b. COUNTY Wash.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS RD6-Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Female		White	WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	74	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME		Home		Wash. Co, Md		U.S.A.		
14. MOTHER'S MAIDEN NAME		Elizabeth Shank						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No		None		Edward M. Eby		RD4 Hagerstown, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion INTERVAL BETWEEN DUE TO ONSET AND DEATH 5 min						
420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cited embolism heart from 5 years						
(b)								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 1-3-58 to 1-3-58, that I last saw the deceased alive on 1-3-58, and that death occurred at 4:15 P.M. from the causes and on the date stated above.		ADDRESS (City, town, or town, state) DATE SIGNED M.D. 1/4/58						
ACTUAL SIGNATURE		Signature Hagerstown, Md 1/4/58						
PHYSICIAN'S NAME (Type)		Signature Hagerstown, Md 1/4/58						
220. BURIAL/CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)		
Burial 1/7/58		Ruff Cem.		Cearfoss, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 8 '58		24b. REGISTRAR'S SIGNATURE A. E. Minnick Greencastle, Pa. W. L. Schuck		

Aug 8 1958

REFUGEE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Binford 1200

CERTIFICATE OF DEATH

01197

302

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 41 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 56 Broadway				d. STREET ADDRESS 56 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First ANNIE	Middle ELIZA	Last EMMERT	4. DATE OF DEATH Month January	Day 30	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1885	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? nr. Sharpsburg, Wash. Co.		
13. FATHER'S NAME Peter Remsberg				14. MOTHER'S MAIDEN NAME Mary Myers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Leonard R. Emmert-14 Hawthorne Rd.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
INTERVAL BETWEEN ONSET AND DEATH 1-2 hr.								
unknown.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 8 Sept , 1952, to 20 Jan , 1958, that I last saw the deceased alive on 20 Jan , 1958, and that death occurred at 9A M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Richard T. Binford</i>							ADDRESS (Street, city or town, state) 1135 Potomac Ave., Hagerstown, Md.	
DATE SIGNED 31 Jan '58.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE FEB 3 '58		24b. REGISTRAR'S SIGNATURE Al. Smith		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES GOVERNMENT - SECURITY INFORMATION
CERTIFICATE OF DEATH

BUREAU V. S.

FEB 3 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1201 CERTIFICATE OF DEATH**

011198

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 20YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 1 337 N. LOCUST ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First HARLEY	Middle DENNIS	Lost EVANS	4. DATE OF DEATH JANUARY	Month 17	Doy 1958
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/1/1896	9. AGE (In years lost birthday) 61 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FEED MILL		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME JENNIE EVANS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO		16. SOCIAL SECURITY NO. 236-28-5196		17. INFORMANT MRS. EDNA B. EVANS		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. } (b) Hypertension cardio vascular 2021/01/01 year DUE TO (c) Diabetes mellitus year				INTERVAL BETWEEN ONSET AND DEATH 2 wks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 Jan 1956, to 17 Jan 1956, that I last saw the deceased alive on 16 Jan 1956, and that death occurred at 3304 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Eldredge Goodell M.D.</i>				ADDRESS (Street, city or town, state) Hagerstown MD DATE SIGNED 11/1/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/19/58		22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 21 '58	24b. REGISTRAR'S SIGNATURE <i>Asst. Reg.</i>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 21 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01199

1244

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN lb 60 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 E. Water St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
f. STREET ADDRESS 10 E. Water St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna First Middle Last Ferguson		4. DATE OF DEATH Month Jan. Day 2 Year 1958	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH August 11, 1881
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY own home	
10c. BIRTHPLACE (State or foreign country) Charmian, Penna.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Eloise Smith, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29-, 19 57, to 1-2-58, 19 , that I last saw the deceased alive on 1-1-, 19 58, and that death occurred at 9:15 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Charles F. Hess M.D. ADDRESS (Street, city or town, state) Smithsburg, Maryland DATE SIGNED			
PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.		1-2-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-4-58	
22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery		22d. LOCATION (City, town, or county) Smithsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 6 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE A. Minnich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DATE

BUREAU V.

JAN 6 1953

K-RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G224 1-23-58 at

01200

1202

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. Pennsylvania Washington Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 22 months	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home 1223 Virginia Ave	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75x3		
3. NAME OF DECEASED (Type or print) SAMUEL	First S	Middle WOPE	Last FLEAGLE
4. DATE OF DEATH Jan. 14 1958	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 23, 1865
9. AGE (In years lost birthday) 92 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Maryland R.R. Clerk and Ticket agent		10b. KIND OF BUSINESS OR INDUSTRY Carroll Co. Md.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Elia Fleagle		14. MOTHER'S MAIDEN NAME Julian Warrenfeltz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. S. S. Fleagle 34 Clayton Ave.		Address Waynesboro, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerotic Heart Disease 10 yr (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Basal cell carcinoma of left ear			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 24, 1956, to Jan 14, 1958, that I last saw the deceased alive on Jan 9, 1958, and that death occurred at 10 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 217 W. Washington Street DATE SIGNED			
ACTUAL SIGNATURE Edward W. Ditto			
PHYSICIAN'S NAME (Type) Edward W. Ditto M.D.		1/11/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/17/58	22c. NAME OF CEMETERY OR CREMATORIAL Burns Hill	22d. LOCATION (City, town, or county) Waynesboro (State) Penna.
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Gore		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 17 '58
			24b. REGISTRAR'S SIGNATURE Alt. eough

CERTIFICATE OF DEATH

1500

DEATH

NAME

AGE

SEX

MATERIAL

CAUSE

TIME

PLACE

BUREAU V.

JAN 17 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1203

CERTIFICATE OF DEATH

Reg. Dist. No.

01201

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Williamsport Md RFD 2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Williamsport RFD #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Cordelia	Middle J	Last Fridinger	4. DATE OF DEATH	Month Jan.	Day 4	Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4 1871	9. AGE (In years (last birthday) yrs.) 86	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 0	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME William Rudy				14. MOTHER'S MAIDEN NAME Mary E Muney				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. William Fridinger		Address Williamsport Md RFD #2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.3 DUE TO Carcinoma of Sigmoid Colon INTERVAL BETWEEN ONSET AND DEATH 2 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis; Senility 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Jan. 2, 1958 , to Jan 4, 1958 , that I last saw the deceased alive on Jan 3, 1958 , and that death occurred at 3:45 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE John A. Moran M.D. ADDRESS (Street, city or town, state) 215 W. Washington St 14158 DATE SIGNED 1/14/58 PHYSICIAN'S NAME (Type) JOHN A. MORAN Hagerstown, Md.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 6-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery			22d. LOCATION (City, town, or county) Hagerstown Maryland (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md.				ADDRESS	24a. REC'D BY REGISTRAR JAN 7 '58	24b. REGISTRAR'S SIGNATURE W. Louch		

8361 L NH

DE ALZADA

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01202

1204

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 30 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 331 Valley Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) First GILSON Middle E Last FUSS		4. DATE OF DEATH Jan. 23 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Feb. 15, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Toolmaker		10b. KIND OF BUSINESS OR INDUSTRY Machinery	
11. BIRTHPLACE (State or foreign country) Franklin County, Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. Fuss		14. MOTHER'S MAIDEN NAME Barbara Ann Beaver	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-10-3290 17. INFORMANT Mrs. G. E. Fuss Address 331 Valley Rd. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion INTERVAL BETWEEN ONSET AND DEATH 10 min			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary arteriosclerosis (c)		1 month	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 15, 1957, to Jan. 28, 1958, that I last saw the deceased alive on Jan. 3, 1958, and that death occurred at 10 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Paul Harrison M.D. ADDRESS (Street, city or town, state) 318 North Potomac St. 1/23/58 DATE SIGNED 1/23/58			
PHYSICIAN'S NAME (Type) PAUL HARRISON			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/26/58		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. 24a. REC'D BY REGISTRAR JAN 28 '58	
		24b. REGISTRAR'S SIGNATURE <i>Aut. Deuch</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF DEFENSE - GOVERNMENT OF THE UNITED STATES

CERTIFICATE OF DATA

BUREAU X-4

JAN 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01203

1205

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 2 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MARTIN MANOR NURSING HOME		e. STREET ADDRESS RURAL CLEAR SPRING	
3. NAME OF DECEASED (Type or print) WILLIAM M. GEHR		4. DATE OF DEATH I 2 19 58	Month Day Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN 2, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH GEHR	
14. MOTHER'S MAIDEN NAME ANNA MASON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] No [If yes, give war or dates of service]	
16. SOCIAL SECURITY NO.		17. INFORMANT W.R. GEHR	Address CLEAR SPRING RT I
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Sclerotic Heart Disease 4 yrs. Cancer of Bladder 4 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 9, 1957 to Jan 2, 1958 , that I last saw the deceased alive on Jan 1, 1958 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 1/2/58			
ACTUAL SIGNATURE David R. Brewer		PHYSICIAN'S NAME (Type) David R. Brewer	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 6, 1958	22c. NAME OF CEMETERY OR CREMATORIUM REST HAVEN
22d. LOCATION (City, town, or county) HAGERSTOWN, MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		24a. REC'D BY REGISTRAR DATE JAN 6 1958	24b. REGISTRAR'S SIGNATURE A. W. Madnick

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 2

AN 6 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1206

CERTIFICATE OF DEATH

Reg. Dist. No. 011204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <i>Washington</i>		MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <i>Maryland</i>		b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>HAGERSTOWN</i>		c. LENGTH OF STAY IN 1b <i>65</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>03 HAGERSTOWN</i>		d. STREET ADDRESS <i>70 W. FRANKLIN STREET</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>WESTERN MD STATE HOSPITAL</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>BENJAMIN</i>	Middle <i>FRANKLIN</i>	Last <i>Gift</i>	4. DATE OF DEATH Month <i>JAN.</i>	Day <i>11</i>	Year <i>1958</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 13, 1888</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CONSTRUCTION WORKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>NONE</i>	11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>UNITED STATES</i>	
13. FATHER'S NAME <i>DAVID Gift</i>		14. MOTHER'S MAIDEN NAME <i>REBECCA REED</i>			Address <i>HAGERSTOWN, Md</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-03-1060A</i>	17. INFORMANT <i>Mrs. Vivian TURNER</i>	INTERVAL BETWEEN ONSET AND DEATH <i>2 WEEKS</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONFIDENT Lobular PNEUMONIA</i>						
150X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>TRACHEO-ESOPHAGEAL Fistula</i>					6 MONTHS	
(c) DUE TO <i>CARCINOMA of Esophagus</i>					2 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malnutrition</i>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) <i>WESTERN MD STATE HOSPITAL</i>	(State) <i>Hagerstown, Md.</i>	
21. I certify that I attended the deceased from <i>Nov. 20, 1957</i> , to <i>JAN. 11, 1958</i> , that I last saw the deceased alive on <i>JAN. 11, 1958</i> , and that death occurred at <i>8:45 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE: <i>Evaristo R Lardizabal M.D.</i> ADDRESS (Street, city or town, state) <i>WESTERN MD STATE HOSPITAL</i> DATE SIGNED <i></i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/19/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Rose Hill Cem. Hagerstown</i>	22d. LOCATION (City, town, & county) <i>Hagerstown, Md.</i>	(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Dr. Hormann, Hagerstown, Md.</i>		ADDRESS <i></i>	24a. REC'D BY REGISTRAR <i>14 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Albert J. Schaeffer</i>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01205

Reg. Dist. No. 302

CERTIFICATE OF DEATH

1207

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 4 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Nursing Home		d. STREET ADDRESS Main St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLWIM	Middle ALBERT	Last GLESNER	4. DATE OF DEATH	Month Jany	Day 34	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct 7 1865	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months 9	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY Mercersburg Franklin Co USA	
13. FATHER'S NAME Jacob F. Glesner				14. MOTHER'S MAIDEN NAME Margaret McLaughlin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Blanche Conner Maugansville Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c) Arterio sclerotic heart disease 10 yrs Debility							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-1-1971 to 1-22-1958 , that I last saw the deceased alive on 1-22-1958 , and that death occurred at Hagerstown Md , from the causes and on the date stated above.							
ACTUAL SIGNATURE Dr J W Ditty		M.D.		ADDRESS (Street, city or town, state) Hagerstown Md		DATE SIGNED 1/27/58	
PHYSICIAN'S NAME (Type) Dr J W Ditty		Hagerstown Md 1/27/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/27/58	22c. NAME OF CEMETERY OR CREMATORIUM Dunkard Cemetery		22d. LOCATION (City, town, or county) Broadfording Wash Co		(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS DATE 24a. REC'D BY REGISTRAR JAN 28 1958					
		24b. REGISTRAR'S SIGNATURE John Smith					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEW JERSEY STATE DEPARTMENT OF HEALTH - RECORDS

CERTIFICATE OF DEATH

RECEIVED

BUREAU X

JAN 28 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1208

CERTIFICATE OF DEATH

01206

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1016 MULBERRY AVE.		d. STREET ADDRESS 1016 MULBERRY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) WILLIAM HAROLD GRAY		First	Middle	Last	4. DATE OF DEATH JANUARY 13 1958	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH MAY 28 1897	9. AGE (In years lost birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RADIO ANNOUNCER STATION W.J.E.J.		10b. KIND OF BUSINESS OR INDUSTRY STATION W.J.E.J.		11. BIRTHPLACE (State or foreign country) ROANOKE VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME STOKELEY E. GRAY		14. MOTHER'S MAIDEN NAME LOU ANN SPARKS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT STATION W.J.E.J. HAGERSTOWN MD.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO CORONARY ARTERIOSCLEROSIS (c)		CORONARY OCCUSION				INTERVAL BETWEEN ONSET AND DEATH 10 min.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 10, 1957 , to Nov 20, 1957 , that I last saw the deceased alive on Nov 20, 1957 , and that death occurred at ? M. , from the causes and on the date stated above. ACTUAL SIGNATURE Paul Harrison		M.D.		ADDRESS (Street, city or town, state) 318 N. Potomac St		DATE SIGNED 1/14/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 16 1958		22c. NAME OF CEMETERY OR CREMATORIUM EVERGREEN CEMETERY		22d. LOCATION (City, town, or county) ROANOKE VIRGINIA		
23. FUNERAL DIRECTOR'S SIGNATURE Paul J. Harrison		ADDRESS Baltimore Md		24a. REC'D. BY REGISTRAR JAN 16 1958		24b. REGISTRAR'S SIGNATURE John J. Schaeffer		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registration, or removal, and in any event within 72 hours after death.

BUREAU V. S.
JAN 16 1958
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1245

CERTIFICATE OF DEATH

Reg. Dist. No.

01207

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		d. STREET ADDRESS 126 North Conococheague Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 126 North Conococheague Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Fred	Middle Walter	Last Harrison	4. DATE OF DEATH	Month Jan.	Day 23	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 11 1886	9. AGE (In years last birthday) 71 yrs.	IF UNDER 1 YEAR 3	IF UNDER 24 HRS. 12	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY BRICK YARD		11. BIRTHPLACE (State or foreign country) St. Thomas Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Harrison				14. MOTHER'S MAIDEN NAME Elizabeth Gift			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-09-9240		17. INFORMANT Mrs. Harry Banzhoff		Address 126 N. Conococheague Williamsport Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH deceased Harrison & deceased wife							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Williamsport	(County) Lycoming Co	(State) Pennsylvania
21. I certify that I attended the deceased from 12/22/58 , 19 58 , to 12/23/58 , 19 58 , that I last saw the deceased alive on 12/23/58 , 19 58 , and that death occurred at Williamsport , M, from the causes and on the date stated above. ACTUAL SIGNATURE Albert L. Young							
ADDRESS (Street, city or town, state) 126 N. Conococheague Williamsport Md							
DATE SIGNED 12/27/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 26-58	22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf Williamsport Md				24a. REC'D BY REGISTRAR JAN 27 '58	24b. REGISTRAR'S SIGNATURE DeLoach		

CERTIFICATE OF DEATH

MAY 1939

RECEIVED
BUREAU V.T.

MAY 27 1939

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G224 1-21-58 et.

01208

1209

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 14 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) ELSA		First EBERLY	Middle HASSETT
4. DATE OF DEATH January 18 1958		Month January	Day 18
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH September 14, 1899		9. AGE (In years lost birthday) 58 7/11 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Washington, D. C.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Rothrock		14. MOTHER'S MAIDEN NAME Catherine Eberly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT William R. Moore III Hagerstown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1952 DUE TO Cerebral Metastases INTERVAL BETWEEN ONSET AND DEATH 10 wks.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Malignant tumor of thymus (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1 yr. +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec 10, 1956 , to Jan 15, 1958 , that I last saw the deceased alive on Dec 11, 1956 , and that death occurred at 11:40 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE Lloyd A. Hoffman		ADDRESS (Street, city or town, state) Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland		(State)	
22e. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR JAN 22 '58
			24b. REGISTRAR'S SIGNATURE John Leach

MARYLAND STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM J. HARRIS	54	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
101 E. 20TH ST.	APT. 202	BALTIMORE	MARYLAND
NAME OF DOCTOR	NAME OF HOSPITAL	NAME OF FUNERAL HOME	NAME OF CEMETERY
DR. R. L. COOPER	HAROLD HOSPITAL	WILLIAMS FURNACE	WOODLAND CEMETERY
TIME OF DEATH	DATE OF DEATH	TIME OF BURIAL	DATE OF BURIAL
10:00 A.M.	JAN 22 1958	10:00 A.M.	JAN 22 1958
BUREAU V. S.			
RECEIVED			

JAN 22 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01209

**FOR STATE
HEALTH-DEPT.**

1

 Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

Item 7, Film G224, 1/21/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 Yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 301½ N. Jonathan Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Odious (No) Jackson		4. DATE OF DEATH Month Jan. Day 14 Year 58	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 22, 1881	9. AGE (in years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Church	11. BIRTHPLACE (State or foreign country) Hillsboro Va.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. Cernelia Eubanks 647 Forest Dr. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Arteriosclerotic myocardial heart disease with myocardial failure grade IV INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		None	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) —		(County) — (State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Jan. 14 '58
EXAMINER'S NAME (Type) S. Robert Wells, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 19, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Wash Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>John R. Watson Jr. Hagerstown Md</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 16 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred E. Eubanks</i>

WISCONSIN STATE EXAMINER'S CERTIFICATE OF DEATH

BUREAU V.

JAN 16 1963

RECEIVED

1

**FOR STATE
HEALTH DEPT.**

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by you.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01210

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
Washington MARYLAND		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hagerstown	50 yrs.	03 Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
135 Fairground Ave.		135 Fairground Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MINNIE	Middle F	Last JAMESON
4. DATE OF DEATH	Month Jan.	Day 14	Year 1958
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	June 24, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housewife		Own home	Chestnut Grove, Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
George Holmes		Elizabeth Mobley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT
		214-16-0807	Mrs. Lola V. Fales R #1 Hagerstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
Arteriosclerotic myocardial heart disease			
with myocardial failure grade iv			
422.1 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
None			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
none			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour o. m. p. m.	none 19	While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	none
20f. (City or town)	(County)	(State)	
-		-	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		1-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)
Burial	1/21/58	Rest Haven Cemetery	Hagerstown
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
Rest Haven Funeral Chapel Inc.		1601 Penna. Ave.	JAN 22 '58
			24b. REGISTRAR'S SIGNATURE
			<i>Deborah</i>

RECEIVED
BUREAU V. S.

JAN 22 1958

18. MEDICAL EXAMINER'S CERTIFICATE OF DEATH
DEPARTMENT OF PUBLIC SAFETY - CALIFORNIA STATE POLICE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1246

CERTIFICATE OF DEATH

01211

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Hagerstown, Md.

c. LENGTH OF STAY IN 1b

32 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Gateway Nursing Home

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

DATE
OF
DEATH

Month

Day

Year

Richard

Venney

Jan 10

1958

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

B. DATE OF BIRTH

Male

White

WIDOWED DIVORCED

Oct. 11, 1881

9. AGE (In years
last birthday)

76

yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Conductor

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Muncy, Penna.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Venney

14. MOTHER'S MAIDEN NAME

Mary Ann Carter

Address

1135 Stanley Ave
Chambersburg, Pa.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Mrs Maurice Beringer

1135 Stanley Ave
Chambersburg, Pa.INTERVAL BETWEEN
ONSET AND DEATH

7 yrs.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

157X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)
(County) (State)

21. I certify that I attended the deceased from July 18, 1957, to Jan 10, 1958, that I last saw the deceased alive on Jan 9, 1958, and that death occurred at 1135 Stanley Ave, M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATUREPHYSICIAN'S
NAME (Type)

M.D.

Clear Spring Md. 1/10/58

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Dr. Fred W. Krauss

ADDRESS

Highkirk

Md.

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Date: Jan 15, 1958

Deborah

WISCONSIN STATE DEPARTMENT OF JUSTICE - CALUMETTE

1958 CERTIFICATE OF DEATH

BUREAU V.

JAN 15 1958

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film C221 1-20-58 et

01212

1247

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrots Mill	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrots Mill	
d. NAME OF HOSPITAL (If not in hospital, give street address) Garrots Mill		d. STREET ADDRESS Garrots Mill	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Eliza	First	Middle - Johnson	4. DATE OF DEATH January 10 1958
5. SEX F	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1866
9. AGE (In years ^{Actual birthday} 92 yrs.)		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		Address Baltimore 14, Md. 2316 Montebello	
13. FATHER'S NAME Tom Smallwood			
14. MOTHER'S MAIDEN NAME Cassie Bush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT William D. Johnson
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-2-1958 to 1-11-1958, that I last saw the deceased alive on 1-10-1958, and that death occurred at 12:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md. DATE SIGNED 1-11-58			
ACTUAL SIGNATURE			
PHYSICIAN'S NAME (Type) Dr. Charles Eugene Pruitt			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-14-1958	22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Valley
22d. LOCATION (City, town, or county) (State) Garrots Mill Md.		23. FUNERAL DIRECTOR'S SIGNATURE Elva V. Feete Pleasant Valley Md.	
24a. REC'D BY REGISTRAR DATE JAN 15 '58		24b. REGISTRAR'S SIGNATURE Audrey	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

EST. 1901 CHROMITAS-EST. 1911 40' THICKNESS 20' WIDTH 12' DEPTH 17' DEEP

BUREAU V. S.

Aug 15 1968

REGELV EDITIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11213

1212

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1115 Mt. Etna Road		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
3. NAME OF DECEASED (Type or print) First BERNICE Middle Oswald Last Kindle		d. STREET ADDRESS 1115 Mt. Etna Rd.	
4. DATE OF DEATH January 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 1/30/1863	
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years lost birthday) 94 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Wolfville, Md.		12. CITIZEN OF WHAT COUNTRY? CP.S.A.	
13. FATHER'S NAME John Wesley Hoover		14. MOTHER'S MAIDEN NAME SARAH M. OSWALD	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Anna Lynch - Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH 1 Hour	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO		Cedarsacay Listerinosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/3/58, 19, to 1/3/58, 19, that I last saw the deceased alive on 1/3/58, and that death occurred at 9:45 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Ralph P. Young M.D.		DATE SIGNED 1/4/58	
PHYSICIAN'S NAME (Type) RAPPH P. YOUNG			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/5/58	
22c. NAME OF CEMETERY OR CREMATORIUM Funks town		22d. LOCATION (City, town, or county) Funks town, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Mennich		24a. REC'D BY REGISTRAR ADDRESS Green castle, Pa. DATE JAN 8 '58	
		24b. REGISTRAR'S SIGNATURE Al. Leach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

9935

RECEIVED
JAN 8 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1213

CERTIFICATE OF DEATH

Reg. Dist. No.

01214

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb 2 weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Chewsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Charles	Middle Robert	Last Kinna
4. DATE OF DEATH Month Jan. 21, Day Year 1958			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 9, 1909
8. AGE (In years last birthday) 48 yrs.		9. IF UNDER 1 YEAR Months Days	10. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY public school	11. BIRTHPLACE (State or foreign country) Chewsville, Md.
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Charles Kinna		14. MOTHER'S MAIDEN NAME Anne Bachtell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Charlotte Kinna, Chewsville, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 445x DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH 10 days Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Malignant Hypertension 2 wks. (c) Benign Essential Hypertension 15 years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 NO. POTOMAC ST. ACTUAL SIGNATURE J. D. WILSON, M.D. DATE SIGNED 1/21/58 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-24-58	22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery	22d. LOCATION (City, town, or county) (State) Smithsburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D. BY REGISTRAR JAN 27 58	24b. REGISTRAR'S SIGNATURE W. E. Lee

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BUREAU V.

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REGALIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1214

CERTIFICATE OF DEATH

01215

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1 941 Main Ave.				
3. NAME OF DECEASED (Type or print)	First SYLVIAN JAMES	Middle KLINK,	Last Twin DATE OF DEATH Month Day Year Jan 11 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1/10/58			
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. Months Days Hours Min. 16 41			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY -----	11. BIRTHPLACE (State or foreign country) Hagerstown, Md.			
		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Harold E. Klink		14. MOTHER'S MAIDEN NAME Virginia L. Tyler				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Mr. Harold E. Klink 941 Main Ave. Hagerstown, Md.			
		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 762.5		INTERVAL BETWEEN ONSET AND DEATH 16 hrs				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Algetasis - Severe Prematurity				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County)	(State)
21. I certify that I attended the deceased from 1/10/58 to 1/14/58, that I last saw the deceased alive on 1/10/58, and that death occurred at 3A M, from the causes and on the date stated above. ACTUAL SIGNATURE A.M. Bacon M.D.						
ADDRESS (Street, city or town, state) DATE SIGNED 1/13/58						
PHYSICIAN'S NAME (Type)		302 N. Potomac St. Hagerstown, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/13/58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown	(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel		ADDRESS 1601 Penna. Ave Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE 1 5 '58	24b. REGISTRAR'S SIGNATURE DeLoach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - BACTERIOLOGY TO

CERTIFICATE OF DEATH

BUREAU V. S.
FEB 16 1933
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG224 1-13-58 et

01216

1248

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>VIRGINIA</i>		b. COUNTY <i>Loudoun</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Williamsport</i>		c. LENGTH OF STAY IN 1b <i>6 mos - 13 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Leesburg</i>		d. STREET ADDRESS <i>83X-3</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Williamsport Sanitarium</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Allene</i>		First	Middle	Last	4. DATE OF DEATH <i>Lacy</i>	Month <i>January</i>	Day <i>2</i>	Year <i>1958</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 15, 1881</i>		9. AGE (In years last birthday) <i>76 1/2 yrs.</i>	IF UNDER 1 YEAR Months <i>76 1/2</i>		IF UNDER 24 HRS. Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Dr. H Allen Tupper</i>		14. MOTHER'S MAIDEN NAME <i>Molly Pender</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mrs. Mollie Winn, Fort Ritchie, Md.</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>381X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		Acute vascular accident		INTERVAL BETWEEN ONSET AND DEATH <i>4 hours.</i>				
Cerebral Vascular Encephalopathy		2 yrs.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <i>6/24</i> , 19 <i>57</i> , to <i>2 Jan</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>3 Jan</i> , 19 <i>58</i> , and that death occurred at <i>7 1/2 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>280, Jerome Street Williamsport, Md.</i>		DATE SIGNED <i>2 Jan 58</i>		
ACTUAL SIGNATURE <i>Dane Haak</i>		M.D.						
PHYSICIAN'S NAME (Type) <i>PAUL HAAK, M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>Jan. 3, 1958</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>J. William Lee Crematory</i>		22d. LOCATION (City, town, or county) <i>Washington D.C.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert L. Leaf</i>		ADDRESS <i>Williamsport, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 6 1958</i>		24b. REGISTRAR'S SIGNATURE <i>A. Medicich</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILFREDO SIALE-BERWILL DE HERNANDEZ-GARIBOLDI 10

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1963

REGISTRATION
DEPARTMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1215

CERTIFICATE OF DEATH

Reg. Dist. No. 01217

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Pa.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>		b. COUNTY <i>Franklin</i>	
c. LENGTH OF STAY IN 1b <i>75 x .3</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Greencastle</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Wash. Co. Hospital</i>		d. STREET ADDRESS <i>42 N. Carl Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>Williams</i>	Last <i>Laubs</i>
4. DATE OF DEATH	Month <i>Jan.</i>	Day <i>20</i>	Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/24/1880</i>
9. AGE (In years lost birthday) yrs. <i>77</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rail road worker</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Cabinet maker</i>	11. BIRTHPLACE (State or foreign country) <i>Greencastle</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>William Laubs</i>	14. MOTHER'S MAIDEN NAME <i>Catherine Byers</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>172-01-9401</i>	17. INFORMANT <i>Jerry Laubs - Greencastle, Pa.</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Cerebral Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>	
332 X DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b) <i>Generalized Arterio-Sclerosis</i>		DUE TO <i>20 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <i>Hernia</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>June 1958</i> p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Greencastle, Pa.</i>	20f. (City or town) <i>Greencastle</i> (County) <i>Franklin</i> (State) <i>Pa.</i>
21. I certify that I attended the deceased from <i>June 1958</i> to <i>Jan 1958</i> , that I last saw the deceased alive on <i>20 Jan 1958</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>P. F. Webster</i> PHYSICIAN'S NAME (Type) <i>P. F. WEBSTER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>B.</i>	22b. DATE THEREOF <i>1/25/58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) <i>Greencastle, Pa.</i> (State) <i>Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. E. Munnoch</i>	ADDRESS <i>Greencastle, Pa.</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 23 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Albert J. Lewis</i>

WISCONSIN STATE DEPARTMENT OF HEALTH - AUTUMNE 19

CERTIFICATE OF DATA

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WISCONSIN

1958

1958

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JAN 23 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01218

1249

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitorium		d. STREET ADDRESS 632 Guilford Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Frederick		First William	Middle Lillard	Last Lillard	4. DATE OF DEATH January 7 1958	Month January	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1899	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager		10b. KIND OF BUSINESS OR INDUSTRY Bus Co.		11. BIRTHPLACE (State or foreign country) Page Co. Va.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME William A. Lillard		14. MOTHER'S MAIDEN NAME Elizabeth F. Strickler						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-14-9569		17. INFORMANT Mrs Virginia Lillard Hagerstown Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia - bronchitis						INTERVAL BETWEEN ONSET AND DEATH 4 days		
491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO						
(c)		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malignant hypertension vascular disease - 10 yrs.								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 1954 to Jan 6, 1958						
20c. TIME OF INJURY Hour o. p. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 214 N. Potomac St Hag. Md.		20f. (City or town) Hagerstown	(County) Washington	(State) Md.	
21. I certify that I attended the deceased from Jan 6, 1958 , to Jan 6, 1958 , that I last saw the deceased alive on Jan 6, 1958 , and that death occurred at 12:30 PM , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) M.D. 214 N. Potomac St Hag. Md.								
DATE SIGNED 1/9/58								
ACTUAL SIGNATURE <i>Lloyd A. Hoffman</i>		PHYSICIAN'S NAME (Type) Dr. Lloyd A. Hoffman						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-9-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '58		24b. REGISTRAR'S SIGNATURE <i>Asst. Registrar</i>		

VERMONT STATE DEPARTMENT OF HEALTH - DEATHS 18

CERTIFICATE OF DEATH

Date of Birth

Name of Deceased

Cause of Death

Name of Physician

Name of Hospital

Age at Death

Sex

Place of Death

Cause of Death

Name of Physician

Name of Hospital

Cause of Death

Name of Physician

Name of Hospital

Cause of Death

Name of Physician

Name of Hospital

Cause of Death

Name of Physician

Name of Hospital

Cause of Death

Name of Physician

Name of Hospital

Cause of Death

Name of Physician

Name of Hospital

Cause of Death

Name of Physician

Name of Hospital

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1216 CERTIFICATE OF DEATH

Reg. Dist. No. 305

11219

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN lb 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Leitersburg Route 5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Helen	First Irene	Middle Lushbaugh	Last
4. DATE OF DEATH January 23	Month	Day	Year 19 58
5. SEX Fe Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 17 1903
9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 11 Days 3	11. IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Top Stitcher		10b. KIND OF BUSINESS OR INDUSTRY Waynesboro shoe	11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME James Jenkins		14. MOTHER'S MAIDEN NAME Carrie Slick	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-3047	17. INFORMANT Carl E Lushbaugh
		Address Hagerstown Route 5	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Helen Carcinoma of Cervix with general</i> DUE TO <i>191X</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>18 mos.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) <i>pelvic metastasis</i>	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Hypertensive Cardiovascular Disease</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hagerstown		(County) (State) Wash. Co. Maryland	
21. I certify that I attended the deceased from Dec 25, 1957, to Jan 23, 1958, that I last saw the deceased alive on Jan 22, 1958, and that death occurred at 12 1/2 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward W. Dittman, M.D.</i>		ADDRESS (Street, city or town, state) 212 W. Washington St. 1/23/58	
DATE SIGNED 1/23/58			
PHYSICIAN'S NAME (Type) <i>Edward W. Dittman, M.D.</i>		HAGERSTOWN, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF January 25 1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill	22d. LOCATION (City, town or county) Wash. Co. (State) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 28 '58	
		24b. REGISTRAR'S SIGNATURE <i>D. L. Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

WILSON-CARSON'S DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

RECEIVED

RECORDED

SEARCHED

INDEXED

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FILED

BUREAU V. S.

JAN 23 1958

REGEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1250

CERTIFICATE OF DEATH

Reg. Dist. No. 01220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va.		b. COUNTY Berkeley		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 7 Mos. 4 Wks.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg		d. STREET ADDRESS 377 Boyd Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Bertha		First Bertha	Middle Lena	Last Miles	4. DATE OF DEATH January 25, 1958	Month January	Day 25	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 28, 1882		9. AGE (in years last birthday) yrs. 75	IF UNDER 1 YEAR Months 11	IF UNDER 24 HRS. Days 28	Hours Min. 00 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House duties		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Martinsburg W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Imbach		14. MOTHER'S MAIDEN NAME Julia Lampas						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [If yes, give war or dates of service]		17. INFORMANT Bruce F. Miles		Address Martinsburg W.Va.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage						INTERVAL BETWEEN ONSET AND DEATH 42 hr.		
331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerosis, Generalized		(b) DUE TO Diabetes Mellitus		(c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260X						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OP. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) March 1957 To Jan 25, 1958						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 124 So Raleigh St Martinsburg W.Va	20f. (City or town) MARTINSBURG W.VA	(County) MARTINSBURG	(State) W.VA.	
21. I certify that I attended the deceased from March 1957 To Jan 25, 1958 , that I last saw the deceased alive on Nov 1957 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) MARTINSBURG W.VA DATE SIGNED 11/27/58								
ACTUAL SIGNATURE WRMCUNE		M.D. 124 So Raleigh St Martinsburg W.Va						
PHYSICIAN'S NAME (Type) WRMCUNE		MARTINSBURG W.VA						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/58	22c. NAME OF CEMETERY OR CREMATORIAL Rosedale Cemetery	22d. LOCATION (City, town, or county) Martinsburg		(State) W.VA.			
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown		ADDRESS Martinsburg W.Va.	24a. REC'D BY REGISTRAR JAN 30 '58	24b. REGISTRAR'S SIGNATURE DeLoach				

CERTIFICATE OF DEATH

BUREAU V.

JAN 30 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01221

CERTIFICATE OF DEATH

Reg. Dist. No.

1251

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SANMAR		c. LENGTH OF STAY IN 1b 2 YEARS		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE VIRGINIA		b. COUNTY FAIRFAX			
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) VIENNA		d. STREET ADDRESS 			
								<input checked="" type="checkbox"/> IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First ANNA		Middle L.		4. DATE OF DEATH JANUARY 8 1958		Month	Day	Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH AUGUST 2 1869		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SANGERVILLE VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME MARTIN GARBEE		14. MOTHER'S MAIDEN NAME ELIZABETH SAYER									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT RECORDS FAHRNEY KEEDY MEMORIAL HOME		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		<i>Generalized arteriosclerosis</i>		<i>Coronary thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH 10 yrs					
								15 months			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Bethesda		(County)		(State)	
21. I certify that I attended the deceased from Jan 8 1958 to Jan 8 1958 , that I last saw the deceased alive on Jan 8 1958 , and that death occurred at Bethesda M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Bethesda MD.									
ACTUAL SIGNATURE G. W. LeVan		DATE SIGNED 1/9/58									
PHYSICIAN'S NAME (Type) G. W. LeVan											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 11 1958		22c. NAME OF CEMETERY OR CREMATORIUM CHURCH OF THE BRETHREN CEMETERY OAKTON VIRGINIA		22d. LOCATION (City, town, or county) OAKTON		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Money & King Funeral Home Vienna Virginia		ADDRESS		24a. REC'D BY REGISTRAR JAN 10 '58		24b. REGISTRAR'S SIGNATURE Releasur					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

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BOA www.boa.com 1-800-221-1234

BUREAU V. S.

AN 10 1953

THE GENEVIEVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01222

1252

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Washington

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Rural Big Pool Md.

c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

X Rural Big Pool Md.

d. STREET ADDRESS

Rural Big Pool Md.

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
ThomasMiddle
AlbertLast
Mills4. DATE
OF
DEATH

1.3.58

Month Day Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

9.15.1877

9. AGE (In years
last birthday)

80

yrs.

10. IF UNDER 1 YEAR

2

Months

11. IF UNDER 24 HRS.

18

Days

Hours

19

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Air Craft

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Washington County Md

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James M Mills

14. MOTHER'S MAIDEN NAME

Mary Long

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

N

16. SOCIAL SECURITY NO.

705-10-5916

17. INFORMANT

Mrs Anna Mills Big Pool Md

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Coronary Heart Disease 2 hrs
Hypertension yrsINTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
White Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Jan 3, 1958, to Jan 3, 1958, that I last saw the deceased
alive on Jan 3, 1958, and that death occurred at M, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

John Shaffer M.D. Hancock, Md. 1/5/58

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

1.6.58

22c. NAME OF CEMETERY OR INCINERATOR

Park Head

22d. LOCATION (City, town, or county)

(State)

Park Head Washington Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

House of Rose Hancock Md

24a. REC'D BY REGISTRAR

DATE JAN 9 '58

24b. REGISTRAR'S SIGNATURE

Date 1/1/58

BUREAU V.

1958 6 N.Y.

ΕΓΕΙΒΕΩ

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1217

CERTIFICATE OF DEATH

01223

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS RFD #1	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Lui	Middle	Last Mioni
4. DATE OF DEATH	Month Jan. 12,	Day	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1880
9. AGE (In years last <u>77</u> birthday) yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	11. KIND OF BUSINESS OR INDUSTRY cement plant	12. BIRTHPLACE (State or foreign country) Treppo Grande, Italy
13. CITIZEN OF WHAT COUNTRY? Italy			
14. FATHER'S NAME Domenico Mioni	15. MOTHER'S MAIDEN NAME unknown		
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	17. SOCIAL SECURITY NO.	18. INFORMANT Wash. Co. Hospital, Hagerstown, Md.	Address
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Myocardial infarction</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Coronary arteriosclerosis</u> unknown (c) <u>Generalized arteriosclerosis</u> unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Hagerstown</u> (County) <u>Maryland</u> (State) <u>Md.</u>
21. I certify that I attended the deceased from <u>Feb. 27</u> , 1956, to <u>Jan. 12</u> , 1958, that I last saw the deceased alive on <u>Jan. 12</u> , 1958, and that death occurred at <u>7:10 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>L.L. Packer Jr.</u> ADDRESS (Street, city or town, state) <u>145 W. Washington St</u> DATE SIGNED <u>1/13/58</u> PHYSICIAN'S NAME (Type) <u>L.L. Packer, Jr. M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-14-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by hospital or attending physician.
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1997 Guidelines

BUREAU V. S.

JAN 15 1953

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1253

CERTIFICATE OF DEATH

111224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 108 Fairview Drive				d. STREET ADDRESS 108 Fairview Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Remus	Middle Lee	Last Moxley	4. DATE OF DEATH	Month January	Day 18	Year 19 58
5. SEX Male	6. COLOR OR RACE B.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 12/8/1893	9. AGE (In years last birthday) 64	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Penn Sand Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Anna Moxley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 217-07-1853		17. INFORMANT Mrs. Kitty L. Moxley		Address Hancock, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Coronary Occlusion Arterial sclerosis INTERVAL BETWEEN ONSET AND DEATH Three							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1445 M		20f. (City or town) (County) (State) Hancock	
21. I certify that I attended the deceased from Jan 18, 1958 to Jan 18, 1958 that I last saw the deceased alive on Jan 8, 1958 , and that death occurred at 1445 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state): Hancock, Md. DATE SIGNED 1/19/58							
ACTUAL SIGNATURE L.M. Sharfer M.D.							
PHYSICIAN'S NAME (Type) L.M. Sharfer MD Hancock Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/1958		22c. NAME OF CEMETERY OR CREMATORIUM River View Cemetery		22d. LOCATION (City, town, or county) (State) Hancock Washington Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard & Son Hancock Md.				ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 21 1958	24b. REGISTRAR'S SIGNATURE Quesada

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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THE STATE OF HAWAII - DEPARTMENT OF
CERTIFICATES OF DEATH

BUREAU Y.

JAN 21 1998

KREGEL V EDE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1254

CERTIFICATE OF DEATH

Reg. Dist. No.

01225

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md RFD		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Maryland RFD 1		d. STREET ADDRESS Pinesburg		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Convalescent Home Inc.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Lucy		First	Middle	Last	4. DATE OF DEATH Mulligan	Month Jan.	Day 9	Year 19 58
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH -- 1872	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. John Eby Williamsport, Md RFD #2		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO DUE TO (c)		Acute Cardiac Failure Chr. Endocarditis		INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 3 yrs.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer M.D.						ADDRESS (Street, city or town, state) Clear Spring Md.		
PHYSICIAN'S NAME (Type) David R. Brewer						DATE SIGNED 1/10/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 12-58		22c. NAME OF CEMETERY OR CREMATORIUM Mennonite Cemetery		22d. LOCATION (City, town, or county) Pinesburg (State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf		ADDRESS Williamsport, Md.		24a. RECORD BY REGISTRAR JAN 14 1958 DATE		24b. REGISTRAR'S SIGNATURE C. ...		

CERTIFICATE OF DEATH

BUREAU V. S.

No. 14 1939

RECEIVED

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1213 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01226

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 years				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 15 W. Antietam St.		e. STREET ADDRESS 15 W. Antietam St.				
3. NAME OF DECEASED (Type or print) Carl		First Theodore	Middle Myers			
4. DATE OF DEATH Jan. 11,		Month Jan.	Doy 11			
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH November 4, 1906		9. AGE (In years last birthday) 51 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk		10b. KIND OF BUSINESS OR INDUSTRY railroad	11. BIRTHPLACE (State or foreign country) Leitersburg, Md.			
13. FATHER'S NAME John H. Myers		14. MOTHER'S MAIDEN NAME Lottie Brown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 705-10-5430	17. INFORMANT Mildred Myers, Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		arteriosclerotic coronary heart disease				
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		coronary thrombosis				
		INTERVAL BETWEEN ONSET AND DEATH 10 days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None				
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) -	(County) -	(State) -
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <i>S. Robert Wells</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-13-58		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		22b. DATE THEREOF 1-15-58		22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22d. LOCATION (City, town, or county) Smithsburg, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 16 '58		24b. REGISTRAR'S SIGNATURE <i>Robert Wells</i>

BUREAU V. S.

JAN 16 1953

REGEVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11227

1219

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1222 Virginia Ave Martins Manor Rest Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro			
d. STREET ADDRESS 56 E. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Ida	Middle Ald.	Last Oller		
4. DATE OF DEATH	Month Jan.	Day 8.	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1867		
9. AGE (In years lost birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Near Rouzerville Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Downin	14. MOTHER'S MAIDEN NAME Susan Barkdoll	Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. J. Edgar Oller, Waynesboro Pa.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute ana Head of jaundice DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. 157X (b) DUE TO (c)	INTERVAL BETWEEN ONSET AND DEATH 15 Mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arterio sclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 Not while p. m. 0 of work <input type="checkbox"/> of work <input type="checkbox"/>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Waynesboro	(County) Franklin	(State) Penn.
21. I certify that I attended the deceased from Dec 29, 1952 , to Jan 8, 1958 , that I last saw the deceased alive on Jan 7, 1958 , and that death occurred at 10 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 217 W. Washington Street					
ACTUAL SIGNATURE Edward W. Ditto III	DATE SIGNED 1/8/58				
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.	Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/11/58	22c. NAME OF CEMETERY OR CREMATORIAL Green Hill	22d. LOCATION (City, town, or county) Waynesboro, Franklin Pa.		
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Gove, Waynesboro Pa.	ADDRESS	24a. REC'D BY REGISTRAR W. Gove	24b. REGISTRAR'S SIGNATURE W. Gove		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-trust Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE HAWAIIAN STATE GOVERNMENT OF HAWAII - GOVERNOR'S OFFICE

CERTIFICATE OF DEATH

BUREAU V. 2

JUN 18 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01228

1. PLACE OF DEATH o. COUNTY		1220 Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 237 Jefferson St.,				d. STREET ADDRESS 237 Jefferson St.,	
3. NAME OF DECEASED (Type or print)		First Minerva	Middle Elizabeth	Last Osborne	4. DATE OF DEATH 1 23 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1898	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Wash. Co. Md.	
13. FATHER'S NAME Charles Hetzer		14. MOTHER'S MAIDEN NAME Ann Moore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James M. Osborne Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 286.5		Inanition. Malnutrition.		INTERVAL BETWEEN ONSET AND DEATH About 6 months.	
Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause first. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Mental condition for past 5 years.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month Day Year 19	20d. INJURY OCCURRED While Nat while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on Jan. 7, 1958,		September, 1953, to Jan. 23, 1958, that I last saw the deceased and that death occurred at 12:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) M.D. 119 North Potomac St. 1-24-58 DATE SIGNED	
ACTUAL SIGNATURE R. A. Bell, M. D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-25-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58	24b. REGISTRAR'S SIGNATURE A. E. Eusek

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81-390M12A-471ASH TO BFM12A190 37A12 DMADV-FAM

BUREAU Y.

1958 27 N.

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1255

CERTIFICATE OF DEATH

Reg. Dist. No.

01229

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Washington</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagers town Rural</i>		c. LENGTH OF STAY IN lb <i>74 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hagerstown</i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2535 Penns. Ave</i>		d. STREET ADDRESS <i>12535 Pennsylvania Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Nellie</i>		First	Middle	Last	4. DATE OF DEATH <i>Peyson</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>June 2nd</i>	9. AGE (In years lost birthday) <i>70 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hoodlum County, Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
13. FATHER'S NAME <i>William Lodge Humphrey</i>		14. MOTHER'S MAIDEN NAME <i>Rose Moore</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>MR. JACK PAXSON</i>		Address <i>HAGERSTOWN, MD.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> DUE TO <i>153.8</i>						INTERVAL BETWEEN ONSET AND DEATH <i>6 years.</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Metastatic Cancer from Colon</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1 Jan</i>		20f. (City or town) <i>1 Jan</i>		(County) <i>1 Jan</i>	(State) <i>1 Jan</i>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ACTUAL SIGNATURE <i>J.D. Wilson</i>								DATE SIGNED <i>1 Jan 1958</i>	
PHYSICIAN'S NAME (Type) <i>J. D. WILSON, M.D.</i>								ADDRESS (Street, city or town, state) <i>135 N. Potomac St. HAGERSTOWN, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>1/4/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Ebenezer</i>		22d. LOCATION (City, town, or county) <i>Round Hill, Virginia</i>		(State) <i>Round Hill, Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hall Funeral Home</i>		ADDRESS <i>Berkeley, Va.</i>		24a. REC'D BY REGISTRAR <i>JAN 3 1958</i>		24b. REGISTRAR'S SIGNATURE <i>P.W. Keddy</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DISEASE

CHAS. L. CO.

BOSTON

MASS.

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BUREAU V.

JAN 3 1968

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH a. COUNTY WASHINGTON	1221 MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	b. COUNTY WASHINGTON						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	c. LENGTH OF STAY IN 1b 9 + YRS.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 03	d. STREET ADDRESS 1452 JEFFERSON BLVD.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 1452 JEFFERSON BLVD.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First JAMES	Middle LEONARD	Last POOLE	4. DATE OF DEATH Month JAN. Day 18 Year 1958					
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 4/3/06	9. AGE (In years last birthday) 51 yrs. IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARETAKER			10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME CLARENCE W. POOLE	14. MOTHER'S MAIDEN NAME MARY VIRGINIA COLSON			Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN	16. SOCIAL SECURITY NO. 770	17. INFORMANT Maggie Poole Jefferson Blvd							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE INTERVAL BETWEEN ONSET AND DEATH 5 MOS.									
420.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARDIAC HYPERTROPHY & DILATATION 5 MOS									
(c) CORONARY ATHEROSCLEROSIS UNKNOWN									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PULMONARY EMPHYSEMA, HEALED MYOCARDIAL INFARCT									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19									
21. I certify that I attended the deceased from JAN. 17, 1958 , to JAN. 18, 1958 , that I last saw the deceased alive on JAN. 18, 1958 , and that death occurred at 6:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)			DATE SIGNED
ACTUAL SIGNATURE <i>George Bercu, M.D.</i>	M.D. WESTERN MARYLAND STATE HOSPITAL 1/18/58								
PHYSICIAN'S NAME (Type) DR. GEORGE BERCU	HAGERSTOWN, MARYLAND.								
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-21-58	22c. NAME OF CEMETERY OR CREMATORIAL Res. Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown	(State) MD					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Res. Haven Funeral Chapel Inc.</i>	ADDRESS Hagerstown	24a. REC'D BY REGISTRAR DATE JAN 22 1958	24b. REGISTRAR'S SIGNATURE <i>Albert Reich</i>						
Ralph M. Martin V. Pies.									

CERTIFICATE OF DEATH

BUREAU V. S.
JAN 22 1953
RECEIVED

01231

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
125 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Downsville Md.		c. LENGTH OF STAY IN lb 25 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Williamsport RFD #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Roy	Middle Mc Kinley	Last Price
4. DATE OF DEATH	Month Jan.	Day 27	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH Dec. 9 1897	9. AGE (In years last birthday) 60 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Loom Fixer		10b. KIND OF BUSINESS OR INDUSTRY Federal Silk Mills	11. BIRTHPLACE (State or foreign country) Toledo Ohio
13. FATHER'S NAME John W. Price		14. MOTHER'S MAIDEN NAME Mary C. Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War		16. SOCIAL SECURITY NO. 214 09 4953	17. INFORMANT Mrs. Lillian Price
		Address Downsville Williamsport Md RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO acute coronary occlusion 2 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	S. Robert Wells M.D.		
EXAMINER'S NAME (Type)	S. Robert Wells M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 30-58	22c. NAME OF CEMETERY OR CREMATORIUM Rosedale Cemetery	22d. LOCATION (City, town, or county) (State) Martinsburg W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Albert L. Ziegler Williamsport, Md		DATE JAN 30 '58	Quesada

WEECHET EXAMINER'S CERTIFICATE OF READING

BUREAU X
RECEIVED
IAN 30 1958

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01232

1222

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 4 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TILGHMANTON			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS BOONSBORO MD. ROUTE 1		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First IRENE	Middle MAY	Last RAGER	4. DATE OF DEATH	Month JANUARY	Day 7	Year 1958
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 23 1876	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 84	Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) TILGHMANTON WASH.CO.MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JACOB MOATS		14. MOTHER'S MAIDEN NAME ANNIE MONGAN		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS PEARL MOATS BOONSBORO MD. R.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
Cordury Throm Boain 18 day							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/16/58 , 19, to 1/17/58 , 19, that I last saw the deceased alive on 1/15/58 , 19, and that death occurred on 1/17/58 , 19, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE Ralph Young							
PHYSICIAN'S NAME (Type) William Young, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JANUARY 9 1958		22c. NAME OF CEMETERY OR CREMATORIUM MANOR CEMETERY NEAR TILGHMANTON WASH.CO.MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph Young		ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR JAN 10 '58		24b. REGISTRAR'S SIGNATURE Ralph Young	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

CERTIFICATE OF DEATH

1900

MURKIN

WILLIAM

HARRIS

BUREAU V. S.

JAN 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01233

1257

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN 1b 55 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 41 S. Main St.		d. STREET ADDRESS 41 S. Main St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) David	First J.	Middle Reeher	Last	4. DATE OF DEATH Jan. 1, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 3/15/1875	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer and		10b. KIND OF BUSINESS OR INDUSTRY Fruit Grower		11. BIRTHPLACE (State or foreign country) Rouzerville Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Reeher				14. MOTHER'S MAIDEN NAME Sarah E. Whitmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Margaret R. Harbaugh, Smithsburg Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X				INTERVAL BETWEEN ONSET AND DEATH 2 Days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Generalized Arteriosclerosis		10 Yrs.			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Smithsburg		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-9 , 1955 , to 1-1 , 1958 , that I last saw the deceased alive on 1-1 , 1958 , and that death occurred at 5.30 P.M. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
DATE SIGNED							
ACTUAL SIGNATURE Charles F. Hess M.D.							
PHYSICIAN'S NAME (Type) Charles F. Hess M.D. Smithsburg, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/58		22c. NAME OF CEMETERY OR CREMATORIAL Smithsburg		22d. LOCATION (City, town, or county) (State) Smithsburg, Washington Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa.				ADDRESS		24a. REC'D BY REGISTRAR ANB	
						24b. REGISTRAR'S SIGNATURE A. Hedricky	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

RECEIVED

RECEIVED
U.S.

AN 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01234

1223

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)						
Washington MARYLAND		a. STATE Maryland	b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hancock Maryland.						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Rural 1						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle					
		Dinah	Mae					
4. DATE OF DEATH		Month	Day					
		1	25					
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) 2 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS.		
F		W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5.1.55	8	Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Infant		Infant		Maryland Washington		U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address				
Clair Ritchey		Eleanor M Barnhart						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT				
No		None		Clair Ritchey R.F.D.1 Hancock Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Meningitis, due to Hemophilus Influenza			48 hours			
340.0 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		none			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Jan. 24, 1958, to Jan. 25, 1958, that I last saw the deceased alive on January 25, 1958, and that death occurred at 7:30 pm, from the causes and on the date stated above.					ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE		Archie Robert Cohen M.D.			Clear Spring, Maryland		1/27/58	
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1.28.58		22c. NAME OF CEMETERY OR CREMATORIAL Union Cemetery		22d. LOCATION (City, town, or county) McConnellburg Fulton Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR Date JAN 31 '58		24b. REGISTRAR'S SIGNATURE D. B. Leach		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by a hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

DEPARTMENT OF HOMELAND SECURITY - SECRETARY

CERTIFICATE OF DEATH

BUREAU V. I.

JAN 31 1998

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the register, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1258

CERTIFICATE OF DEATH

01235

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGAN SVILLE		c. LENGTH OF STAY IN 1b 8 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION NORTH ST.		e. STREET ADDRESS X MAUGAN SVILLE	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JACOB	Middle GUY	Last SHADRACH
4. DATE OF DEATH	Month JANUARY	Day 12	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/15/1890
9. AGE (In years last birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 67	11. IF UNDER 24 HRS. Days 00	12. IF UNDER 24 HRS. Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED STITCHER	10b. KIND OF BUSINESS OR INDUSTRY SHOE CO.	11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JACOB U. SHADRACH	14. MOTHER'S MAIDEN NAME LAURA MONG		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO. 214-09-3045	17. INFORMANT MRS. BETTIE HYSSONG	Address MAUGAN SVILLE MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Vas. Accident DUE TO (c) Arteriosclerosis			
INTERVAL BETWEEN ONSET AND DEATH min			
4 hrs.			
Yes			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Muscular dystrophy + hypertension			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1956 , 19, to 1/12 , 19, that I last saw the deceased alive on Jan 12 , 19, and that death occurred at 20 M. from the causes and on the date stated above. ACTUAL SIGNATURE Louis G. Gant PHYSICIAN'S NAME (Type) Louis G. Gant			
ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 1/13/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/14/58	22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.	ADDRESS W. J. Normant, Hagerstown, Md.	24a. REC'D BY REGISTRAR REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

302

01236

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Antietam Furnace		d. STREET ADDRESS none	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FREDERICK	Middle ELMER	Last SHAFFER	4. DATE OF DEATH January 5 1958	Month January	Day 5	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 4, 1877	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 6	Days 1	IF UNDER 24 HRS. Hours 28 hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Stone Cutter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon L. Shaffer		14. MOTHER'S MAIDEN NAME Susan E. Stouffer				Address Hagerstown, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. none 17. INFORMANT Mr. John Shaffer							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 570.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
<i>Mesenteric Thrombosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x Diabetes.							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. _____ p. m. 19		20d. INJURY OCCURRED white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office building, etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 1-4-58 to 1-5-58 , that I last saw the deceased alive on 1-5-58 , 19, and that death occurred at 255P M, from the causes and on the date stated above. ACTUAL SIGNATURE Robert J. Leadee M.D. ADDRESS (Street, city or town, state) 1-6-58.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home <i>R. Franklin Rogers</i>		ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '58		24b. REGISTRAR'S SIGNATURE <i>Abbie Smith</i>	

THE STATE OF CALIFORNIA

CERTIFICATE OF DEATH

BUREAU V. 2

JAN 13 1958

RECEIVED
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01237

1259

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the register, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 25 West Church Street		e. STREET ADDRESS 125 West Church Street		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Maggie	Middle M	Last Shank	4. DATE OF DEATH	Month Jan.	Day 19	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Feb. 28 1884	8. AGE (In years last birthday) 73	9. IF UNDER 1 YEAR yrs. 10 Months	10. IF UNDER 24 HRS. Months 21	11. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Welsh Run Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Holliday H. Shank		14. MOTHER'S MAIDEN NAME Prudence Miller		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Edward Shank Williamsport Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Odeonate Thruon Bain				INTERVAL BETWEEN ONSET AND DEATH Immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) 		21. I certify that I attended the deceased from _____ 19_____, to _____ 19_____, that I last saw the deceased alive on _____ 19_____, and that death occurred at _____ 3 PM _____ from the causes and on the date stated above. ADDRESS (Street, city or town, state) Western Pike Route 40 Md.			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Field		20f. (City or town) (County) (State) Field	
21. I certify that I attended the deceased from _____ 19_____, to _____ 19_____, that I last saw the deceased alive on _____ 19_____, and that death occurred at _____ 3 PM _____ from the causes and on the date stated above. ADDRESS (Street, city or town, state) Western Pike Route 40 Md.		DATE SIGNED 1/21/58				ACTUAL SIGNATURE Edward Shank Williamsport Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 22-58		22c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) Western Pike Route 40 Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Shank Williamsport, Md.		ADDRESS 125 West Church Street		24a. REC'D BY REGISTRAR DATE JAN 21 '58		24b. REGISTRAR'S SIGNATURE Asafurah	

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1225

CERTIFICATE OF DEATH

Reg. Dist. No.

01238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 6 Months	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv. Home	d. STREET ADDRESS 142 S. Potomac St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle Franklin Last Sipe	4. DATE OF DEATH Month Jan. Day 6, Year 1958		
S. SEX Male White	6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 10, 1874
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, Office		10b. KIND OF BUSINESS OR INDUSTRY Landis Machine Co.	11. BIRTHPLACE (State or foreign country) Carlisle, Pa.
13. FATHER'S NAME Robert F. Sipe		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-0894	17. INFORMANT Dr. Edward Sipe, Waynesboro Pa.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12/30/57, 19, to 19, that I last saw the deceased alive on 12/30/57, 19, and that death occurred at 7:15 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Howard N. Weeks		ADDRESS (Street, city or town, state) 136 North Potomac St. DATE SIGNED 1/2/58	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/58	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Ashland Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove		22d. LOCATION (City, town, or county) Carlisle	24a. REC'D BY REGISTRAR DATE JAN 10 58
			24b. REGISTRAR'S SIGNATURE W. L. Smith Pa.

BUREAU V. S.

JAN 16 1968

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1226

CERTIFICATE OF DEATH

01239

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 915 Chestnut St.,		d. STREET ADDRESS 915 Chestnut St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Susan		First Susan	Middle M	Last Slick	4. DATE OF DEATH 11-16-1878	Month 1	Day 10	Year 19 58	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 11-16-1878	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Middleburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jonas B. Martin				14. MOTHER'S MAIDEN NAME Kathrynn Martin (Boward)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Charles M. Slick		Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute cerebral Heart Disease DUE TO (c) 2 yrs DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Md.	(State) Md.
21. I certify that I attended the deceased from 11-20-58 , to 11-10-58 , that I lost sow the deceased alive on 11-2-58 , and that death occurred at Hagerstown , M.D., from the causes and on the date stated above. ACTUAL SIGNATURE J. W. Dill PHYSICIAN'S NAME (Type) J. W. Dill Rose Hill Hagerstown, Md. 11-10-58 ADDRESS (Street, city or town, state) DATE SIGNED									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-13-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR JAN 14 '58		24b. REGISTRAR'S SIGNATURE D. W. Kraiss	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1227

CERTIFICATE OF DEATH

Reg. Dist. No.

01240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 8 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS RT. #3 HAGERSTOWN	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle HAMILTON	Last SNYDER JR.
4. DATE OF DEATH	Month JANUARY	Day 7	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1890
9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Hours 0	12. IF UNDER 24 HRS Min. 0
10b. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED EXECUTIVE	10b. KIND OF BUSINESS OR INDUSTRY METAL WKS.	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM H. SNYDER	14. MOTHER'S MAIDEN NAME VIRGINIA LINEBAUGH		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO	16. SOCIAL SECURITY NO. 283-07-3477	17. INFORMANT MRS. ELIZABETH W. SNYDER	Address HAGERSTOWN RT. #3 MB.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 541.0			
DUE TO <i>Bleeding Duodenal Ulcer, Chronic</i> INTERVAL BETWEEN ONSET AND DEATH 1 month			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebrovascular sclerosis</i> 2 years			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month Jan	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 28 W. Potowmack Street
20f. (City or town) Williamsport	(County) MD.	(State) PA.	
21. I certify that I attended the deceased from Jan 1958 to Jan 1958 , that I last saw the deceased alive on Jan 1958 , and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Haak, M.D.		ADDRESS (Street, city or town, state) 28 W. Potowmack Street	
PHYSICIAN'S NAME (Type) PAUL HAAK, M.D.		DATE SIGNED 9 Jun 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1/10/58	22c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL CEM.	22d. LOCATION (City, town, or county) HAGERSTOWN
23. FUNERAL DIRECTOR'S SIGNATURE W.J. Normant, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '58	
		24b. REGISTRAR'S SIGNATURE Bill Beaudach	

WISCONSIN STATE DEPARTMENT OF HEALTH—SECTIOME 18

CERTIFICATE OF DEATH

MURKIN, BAGGSDON

BUREAU V. 8

JAN 18 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1228

CERTIFICATE OF DEATH

01241

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 03	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 943 Rose Hill Ave.		e. STREET ADDRESS 943 Rose Hill Ave.	
3. NAME OF DECEASED (Type or print) Joyce		First Joyce	Middle Marie
4. DATE OF DEATH Jan. 25		Last Speaker	Month Day Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 12 1957
9. AGE (In years last birthday) yrs. 6		10. IF UNDER 1 YEAR Months 12	11. IF UNDER 24 HRS. Days 12
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Resley Speaker		14. MOTHER'S MAIDEN NAME Charlotte Shoemaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Resley Speaker		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 057.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Bakersville Cemetery		20f. (City or town) (County) (State) Bakersville Md.	
21. I certify that I attended the deceased from alive on 1/23/58 , and that death occurred on 1/25/58 , that I last saw the deceased M, from the causes and on the date stated above. ACTUAL SIGNATURE Edith V. Leulivilliamsport		ADDRESS (Street, city or town, state) 1228 Bakersville Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25-58	
22c. NAME OF CEMETERY OR CREMATORIUM Bakersville Cemetery		22d. LOCATION (City, town, or county) (State) Bakersville Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edith V. Leulivilliamsport		ADDRESS 1228 Bakersville Md.	24a. REC'D BY REGISTRAR DATE JAN 27 '58
		24b. REGISTRAR'S SIGNATURE Aut. 25	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU Y.

JAN 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01242

1260

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md RF #2		c. LENGTH OF STAY IN 1b 20 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Md. RFD #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Earl	Middle Hager	Last Spielman
4. DATE OF DEATH	Month Jan.	Day 22	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2 1882
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months 20	11. IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	
10c. BIRTHPLACE (State or foreign country) Tilghmanton Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Spielman		14. MOTHER'S MAIDEN NAME Manzela Highbarger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Elsie Walker		Address Bower Ave. Williamsport Md RFD 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO 420.1 Esophageal Thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. M. from the causes and on the date stated above. ACTUAL SIGNATURE Ralph L. Young M.D. ADDRESS (Street, city or town, state) Williamsport, Md. DATE SIGNED 1/24/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 25 '58	22c. NAME OF CEMETERY OR CREMATORIUM Manor Cemetery
22d. LOCATION (City, town, or county) Near Tilghmanton Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert Leof Williamsport, Md.		24a. REC'D BY REGISTRAR DATE JAN 27 '58	24b. REGISTRAR'S SIGNATURE Al. Leof

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED
BUREAU V.E.
JAN 27 1953

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1229 CERTIFICATE OF DEATH

01243

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 16 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 505 Chestnut Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3. NAME OF DECEASED (Type or print) RALPH		4. DATE OF DEATH January 4 1958	
First RALPH	Middle VICTOR	Month January	Day 4
Lost 03	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1897
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Edgemont, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Stone		14. MOTHER'S MAIDEN NAME Rose Harbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mrs. Ruth Stone	
17. INFORMANT Hagerstown, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Jan , 19 58 , to 4 Jan , 19 58 , that I last saw the deceased alive on 4 Jan , 19 58 , and that death occurred at 300 E. Main St. M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE F. F. Lusby		DATE SIGNED 6 Jan 58	
PHYSICIAN'S NAME (Type) F. F. Lusby		M.D. 230 N. Boundary	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/7/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		24a. REC'D BY REGISTRAR JAN 12 '58	
P. Franklin Ponger		24b. REGISTRAR'S SIGNATURE DeLoach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

828 15 44

828: 61 N.

REGELVÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 File #G221 1-22-58 et.

01244

1230

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 Weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 23 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Vash. county Hospital		d. STREET ADDRESS East Oak Ridge Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ARTHUR	Middle GARMAN	Last STOTELMYER	4. DATE OF DEATH Jan. 14 1958	Month Year 19	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Feby 10 1900	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Mason		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Downsville Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey A. Stotelmeyer		14. MOTHER'S MAIDEN NAME Flora May Baker					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-3968		17. INFORMANT Mrs Edna K. Stotelmyer Hagerstown Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X		DUE TO Hypertensive Cardio-Vascular		R # 3 East Oak Ridge Drive		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO disease with uremia due		(c) DUE TO to Renal Failure				6-8 Mo -	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Benign Prostatic Hypertrophy						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from Jan 8, 1958 to Jan 14, 1958 that I last saw the deceased alive on Jan 14, 1958 , and that death occurred at 9 20/79 M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 1/14/58	
ACTUAL SIGNATURE <i>Edward W. Ditto</i>	PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.		Hagerstown, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1/17/58	22b. DATE THEREOF 1/17/58	22c. NAME OF CEMETERY OR CREMATORIUM Manor Cemetery	22d. LOCATION (City, town, or county) near Tilghmanton Wash. Co Md		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 16 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred E. Smith</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

JAN 16 1939

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 111245

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a bier-roll-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb ½ day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 38 N. Potomac Street		d. STREET ADDRESS Hagerstown, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Everly's Department Store				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VIOLA		First AMELIA	Middle STOUFFER	Lost	4. DATE OF DEATH Month January	Day 27	Year 19 58
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 7, 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clinton S. Stouffer				14. MOTHER'S MAIDEN NAME Laura Siegrist			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-7722		17. INFORMANT Mr. Clyde Stouffer Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Vascular Hypertension (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? None YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) None					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) -	(County) -	(State) -	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>S. Robert Wells</i>	EXAMINER'S NAME (Type) S. Robert Wells, M.D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED Jan. 28 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/29/1958	22c. NAME OF CEMETERY OR CREMATORIUM Funkstown Cemetery			22d. LOCATION (City, town, or county) Funkstown, Maryland	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home	ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE JAN 30 '58	24b. REGISTRAR'S SIGNATURE All. L. esch	

WISCONSIN STATE INSURANCE DEPARTMENT
WISCONSIN EXAMINER'S CERTIFICATE OF DEATH

STATE OF
WISCONSIN

BUREAU X. S.

JAN 30 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dr. Binford

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1232

CERTIFICATE OF DEATH

01246

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1 36 South Cannon Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) NANNIE BOWERS STRINE		First	Middle	Last	4. DATE OF DEATH January 6 1958	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1890	9. AGE (In years lost birthday) 67 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Berryville, Clarke Co.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Frank L. Hamilton			14. MOTHER'S MAIDEN NAME Virginia Jennie Hart					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Walter K. Strine-36 S. Cannon Av.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which goe rise to immediate cause (a), stating the under- lying cause lost. (b) Myocardial Infarction DUE TO (c) Coronary occlusion (d) Arteriosclerotic Heart Disease INTERVAL BETWEEN ONSET AND DEATH 5 weeks								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Anoxysm								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County)	(State)	
21. I certify that I attended the deceased from 7 Dec 1957 to 6 Jan 1958 , that I last saw the deceased alive on 5 Jan 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Wash. Co. Md.								
DATE SIGNED Richard T. Binford								
ACTUAL SIGNATURE M.D.								
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Wash. Co. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman-Hagerstown, Maryland				ADDRESS		24a. REC'D BY REGISTRAR DATE 18 '58	24b. REGISTRAR'S SIGNATURE DeLoach	

81 FEDERAL BUDGET REQUEST FOR THE STATE OF CALIFORNIA

JAN 8 1969

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01247

1233

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE	
Washington MARYLAND		Penns. b. COUNTY franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Hagersstown	-	Greencastle 75x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Garlock Conv. Hospital	5. Washington St.		
3. NAME OF DECEASED (Type or print)	First	Middle	Lost 4. DATE OF DEATH Month Day Year
Margaret	R	Rankin	Strite Jan. 10 1958
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 1/10/1875
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 83 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housekeeper & Clerk in Store		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel J. Strite		14. MOTHER'S MAIDEN NAME Mary Belle Ruthrauff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Jessie Shrader - Greencastle, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO <i>Arterio sclerotic heart disease with myocardial failure</i> INTERVAL BETWEEN ONSET AND DEATH 5 yrs +			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? NO			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Inj</i>	
20c. TIME OF INJURY Month, Day, Year Hour p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1950, 19, to 10 Jan, 1958, that I last saw the deceased alive on 10 Jan, 1958, and that death occurred at 5 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>F.F. Lusby</i> ADDRESS (Street, city or town, state) <i>230 N Polomac</i> DATE SIGNED <i>11 Jan 58</i> PHYSICIAN'S NAME (Type) <i>F.F. Lusby</i> M.D. <i>Hagerstown MD</i>			
22a. BURIAL / CREMATION, REMOVED (Specify) <i>b.</i>		22b. DATE THEREOF 1/13/58	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill		22d. LOCATION (City, town, or county) (State) <i>Greencastle, Pa.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE, ADDRESS <i>A.E. Munnoch</i>		24a. REC'D BY REGISTRAR DATE JAN 14 '58 <i>Rec'd 1/14/58</i>	
		24b. REGISTRAR'S SIGNATURE <i>John Smith</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 01248 302	
1234 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 225 Mill Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co Hospital											
3. NAME OF DECEASED (Type or print) Raymond		First	Middle	Lost	4. DATE OF DEATH Jan.	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 23, 1902	9. AGE (In years lost birthday) 55 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY City Water Dept		11. BIRTHPLACE (State or foreign country) Shenandoah Page Co Va		12. CITIZEN OF WHAT COUNTRY USA					
13. FATHER'S NAME William Turner				14. MOTHER'S MAIDEN NAME Eila V.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 230-28-8489		17. INFORMANT Mrs Violet Manford		Address 830 Hamilton Blvd					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 527.1 DUE TO Ventricular fibrillation INTERVAL BETWEEN ONSET AND DEATH 10 min											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO Pulmonary Embolism									
(c)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from July 1955 to 1/23, 1958, that I last saw the deceased alive on 10 Am 1/23, 1958, and that death occurred at 9 P M, from the causes and on the date stated above, ADDRESS (Street, city or town, state) 318 N. Potowmack St Hagerstown, Md.											
ACTUAL SIGNATURE Paul Harrison M.D. DATE SIGNED 1/24/58											
PHYSICIAN'S NAME (Type) Paul Harrison Hagerstown, Md.											
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Wash. Co. Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 28 '58		24b. REGISTRAR'S SIGNATURE Al. Leach		DATE			
VS A15 (4) 1SM 10/57											

BUREAU X. M.

JAN 28 1959

REGELYÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01249

1235

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b --		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>1215 Virginia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <u>FANNIE</u>	Middle <u>JANE</u>	Last <u>WAGELEY</u>	4. DATE OF DEATH <u>Jany 25 1958</u>	Month Jany	Day 25	Year 1958
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Nov 4 1881</u>	9. AGE (In years from birth to last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Berkeley Cty., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Newton Hutzler</u>		14. MOTHER'S MAIDEN NAME <u>Martha Burgess</u>		Address <u>Mrs. Naomi Robinson, 664 Pin Oak Rd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Central Thamban due to</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hagerstown, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332X</u>		DUE TO <u>Central Thamban due to</u>		DUE TO <u>General arteriosclerosis</u>		1-2 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <u>Diabetes Mellitus</u>		(b)		(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>260X Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Hour a. p.m.	Month a. 19	Day p.m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Martinsburg</u>	(County) <u>Berkeley</u>	(State) <u>W. Va.</u>
21. I certify that I attended the deceased from <u>Feb 25, 1958</u> , to <u>Jan 22, 1958</u> , that I last saw the deceased alive on <u>Jan 23, 1958</u> , and that death occurred at <u>87 W. Washington St.</u> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Edward W. Dittmer, M.D., 217 W. Washington St.</u>		DATE SIGNED <u>1/25/58</u>			
ACTUAL SIGNATURE <u>Edward W. Dittmer, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Edward W. Dittmer, M.D., 217 W. Washington St.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-1958</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>New Norborne Cemetery</u>	22d. LOCATION (City, town, or county) <u>Martinsburg, Berkeley, W. Va.</u>	(State) <u>W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman, Hagerstown, Md.</u>		ADDRESS <u>—</u>	24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>			
			DATE <u>JAN 28 '58</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF AGED - RETIRING PERSONS

CERTIFICATE OF DEATH

RECEIVED

RECEIVED

BUREAU Y.

JAN 28 1958

RECEIVED

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1261 CERTIFICATE OF DEATH

01250

Reg. Dist. No.

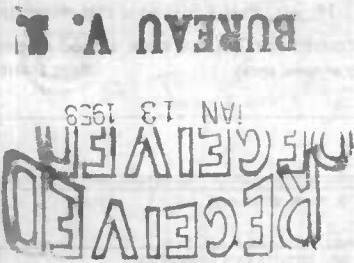
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c. LENGTH OF STAY IN lb 45 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD 1		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg	
3. NAME OF DECEASED (Type or print) James Stanley Webb		d. STREET ADDRESS RFD 1	
4. DATE OF DEATH Jan. 7, 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 25, 1912
9. AGE (In years from birthday) 45 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
11. BIRTHPLACE (State or foreign country) Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel F. Webb		14. MOTHER'S MAIDEN NAME Jennie Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 219001-9615 17. INFORMANT Address Samuel F. Webb, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH 6 yrs			
This man had been treated by Dr. B.B. Kremer for 6 yrs. He is out of town.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-7, 1957, to 1-7, 1958, that I last saw the deceased alive on 1-7, 1957, and that death occurred at 1:45 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert P. Conrad		ADDRESS (Street, city or town, state) 137 W. Washington Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Robert P. Conrad, M.D.		DATE SIGNED 1-7-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-9-58	22c. NAME OF CEMETERY OR CREMATORIAL Mt. Bethel Cemetery
22d. LOCATION (City, town, or county) Garfield, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR DATE JAN 13 '58	24b. REGISTRAR'S SIGNATURE DeLoach

WISCONSIN STATE DEPARTMENT OF HEALTH - LABORATORY

CERTIFICATE OF DEATH

JAN 13 1953

DEATH

BUREAU V. 
DECEIVABLE
JAN 13 1953

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01251

1236

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland		Wa shington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital		d. STREET ADDRESS 918 Rose Hill Cemetery		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CLARENCE		First ALBERT	Middle WELLER	Lost	4. DATE OF DEATH Jany 1 1958	Month Jany	Doy 1	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct 28 1897	9. AGE (in years last birthday) 60	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardner		10b. KIND OF BUSINESS OR INDUSTRY Jamison door Co		11. BIRTHPLACE (State or foreign country) Funkstown Wash. Co Md.		13. FATHER'S NAME Frank Weller		
14. MOTHER'S MAIDEN NAME Clara Stockslager		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 314-09-4037		17. INFORMANT Mrs Elsie K. Weller 918 Rose Hill Ave		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Hagerstown Md.		Labor Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 2 Weeks		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis; Hypertension						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> At work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1135 POTOMAC AVE.	(County)	(State)
21. I certify that I attended the deceased from 26 Dec. 1957 , to 1 Jan. 1958 , that I last saw the deceased alive on 1 Jan. 1958 , and that death occurred at 4 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1135 POTOMAC AVE.								
ACTUAL SIGNATURE <i>Richard T. Binford</i>	DATE SIGNED 2 JAN. 58							
PHYSICIAN'S NAME (Type) RICHARD T. BINFORD	HAGERSTOWN, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/3/58	22c. NAME OF CEMETERY OR CREMATORIUM Funkstown Cemetery		22d. LOCATION (City, town, or county) Funkstown Wash. Co Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 6 1958	24b. REGISTRAR'S SIGNATURE <i>W. Madrich</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANITOBA STATE DEATH CERTIFICATE 19

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 6 1959

REGELIVE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

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81. СИНОДАЛЬНЫЙ РОДОМОСТВОВЫЙ ОКАЗЫВАЕТ
СЕБЯ ВО ВРЕМЯ ПРИЧАСТИЯ КРЕСТОВЫХ КРУГЛЫХ

BUREAU V. S.

JAN 29 1959

RECEIVE EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1262

CERTIFICATE OF DEATH

01253

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		a. STATE Pa. b. COUNTY Franklin ✓	
Rural - Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 75-X-3 Rural - Chambersburg RD 5	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Gateway Convalescent Home		d. STREET ADDRESS Chambersburg RD 5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Harry	Middle C.	Last Wilson	4. DATE OF DEATH Jan. 21 1958
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3/29/1867		9. AGE (In years from birthday) 90 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) Welsh Run, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James K. Wilson		14. MOTHER'S MAIDEN NAME Margaret Hunter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —		17. INFORMANT Mrs. Frank Carbaugh - Hagerstown, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 DUE TO Acute Cardiac Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Chronic Endocarditis } (c) } INTERVAL BETWEEN ONSET AND DEATH 4 days 5 yrs.					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1956 to Jan 21, 1958 that I last saw the deceased alive on Jan 20, 1958, and that death occurred at 06:00 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer M.D. ADDRESS (Street, city or town, state) Clear Spring Md. DATE SIGNED 1/21/58					
PHYSICIAN'S NAME (Type) David R. Brewer					
22a. BURIAL, CREMATION, REMOVAL (Specify) B. 1/24/58		22b. DATE THEREOF 1/24/58		22c. NAME OF CEMETERY OR CREMATORIAL REST Haven	
22d. LOCATION (City, town or county) Hagerstown, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE A.E. Minnick		ADDRESS Greencastle, Pa.		24a. REC'D BY REGISTRAR DATE JAN 22 1958	
				24b. REGISTRAR'S SIGNATURE Oldfield	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V.
Jan 23 1958

JAN 23 1958

REGELEIYE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11254

1268 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
7SM 9/55

1. PLACE OF DEATH o. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
				o. STATE Pa. b. COUNTY Franklin ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural, Bonnboro R.F.D.		3 Months		Waynesboro 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Fahrney-Keedy Home		d. STREET ADDRESS 237 S. Church St.	
3. NAME OF DECEASED (Type or print)		First Ira	Middle Laban	Last Wingert	4. DATE OF DEATH Jan. 5, 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 22, 1881	9. AGE (In years last birthday) 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Machinist		11. BIRTHPLACE (State or foreign country) Waynesboro Pa.	
Retired Custodian				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rev. Laban W. Wingert		14. MOTHER'S MAIDEN NAME Prudence Stover		Address Penna. Waynesboro	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-3777		17. INFORMANT Mrs. John C. Toms, 237 S. Church St., Waynesboro	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		Cancer of colon		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October 5, 1957</u> , to <u>January 5, 1958</u> , that I last saw the deceased alive on <u>January 4, 1957</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>G.W. LeVan</u> M.D. ADDRESS (Street, city or town, state) <u>Waynesboro</u> DATE SIGNED <u>1-5-58</u>					
PHYSICIAN'S NAME (Type) <u>G.W. LeVan M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/8/58		22c. NAME OF CEMETERY OR CREMATORIAL Green Hill	
22d. LOCATION (City, town, or county) Waynesboro, Franklin Penna.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grace</u>		ADDRESS <u>Waynesboro, Pa.</u>		24a. REC'D BY REGISTRAR DATE JAN 8 '58	
				24b. REGISTRAR'S SIGNATURE <u>W. LeVan</u>	

81 BROWNS-SCHEM-DEPARTMENT STORES DIVISION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1264

CERTIFICATE OF DEATH

Reg. Dist. No.

01255

1. PLACE OF DEATH o. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. LENGTH OF STAY IN 1b 2 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 129 So. Liberty St.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Rest Home				d. STREET ADDRESS 129 So. Liberty St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Nettie		First	Middle	Last	4. DATE OF DEATH Wolford	Month	Day	Year			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 18, 1874	9. AGE (In years lost birthday) 83 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Ridgeley, W. Va.		12. CITIZEN OF WHAT COUNTRY U. S. A.					
13. FATHER'S NAME Charles Ridgeley				14. MOTHER'S MAIDEN NAME Elizabeth Thrasher							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Carl Goetz, 1902 Bedford St. Cumberland, Md.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH about 4 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 1	Day 19	Year 1958	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hancock	(County) Allegany	(State) Md.		
21. I certify that I attended the deceased from Nov 1 , 1957, to Jan 16 , 1958, that I last saw the deceased alive on Jan 18 , 1958, and that death occurred at 11:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE H. E. Tabler										ADDRESS (Street, city or town, state) Hancock, Md.	DATE SIGNED 1958
PHYSICIAN'S NAME (Type) H. E. Tabler											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 19, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR JAN 31 '58		24b. REGISTRAR'S SIGNATURE W. E. Smith					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 31 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
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 the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												01256			
Item 2 FilmG221 1-20-58 et												Reg. Dist. No. 302			
CERTIFICATE OF DEATH															
1238															
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown/ Baltimore 13											
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS 1737 Lombard St., East Homewood Church Home								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First LOUIS		Middle KARL		Last ZACHOW		4. DATE OF DEATH January 13		Month 1958		Day 13		Year	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR 9 Months		IF UNDER 24 HRS. 16 Days			
Male		White		WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>		March 27, 1870		87 yrs.		9 16			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Louis Karl Zachow								14. MOTHER'S MAIDEN NAME Paulina Schmidt							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <small>(Yes, no or unknown)</small>				16. SOCIAL SECURITY NO.		17. INFORMANT		Address Rev. Mark Wagner Hagerstown, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.								INTERVAL BETWEEN ONSET AND DEATH							
DUE TO artery occlusion heart disease 10 yrs															
(b) DUE TO															
(c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <small>(IF EITHER, NOTIFY MEDICAL EXAMINER)</small>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Artery occlusion heart disease 10 yrs</i>											
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Hagerstown</i>		(County) <i>Washington</i>		(State) <i>Maryland</i>			
21. I certify that I attended the deceased from 10-1-1971 to 1-13-1958 , that I last saw the deceased alive on 1-13-1958 , and that death occurred at Hagerstown M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown M., Hagerstown Md.												DATE SIGNED 1/13/58			
ACTUAL SIGNATURE <i>S. W. Suter</i>															
PHYSICIAN'S NAME (Type) <i>S. W. Suter</i>															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/1958		22c. NAME OF CEMETERY OR CREMATORIUM Oaklawn Cemetery		22d. LOCATION (City, town, or county) Baltimore									
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Franklin Poyer</i>		ADDRESS <i>Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR JAN 15 '58		24b. REGISTRAR'S SIGNATURE <i>Alv. Schuch</i>									

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01257

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CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE MARYLAND b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN 1b 40 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 23 Poplar Street		e. STREET ADDRESS 23 Poplar Street	
3. NAME OF DECEASED (Type or print) SUSAN		Middle ZIMMERMAN	4. DATE OF DEATH Month January Day 20 Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		11. BIRTHPLACE (State or foreign country) Halfway, Maryland	
13. FATHER'S NAME Monroe Zimmerman		14. MOTHER'S MAIDEN NAME Leah Bitner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Address Miss. Katherine Zimmerman Funkstown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of stomach.		INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)		(Gastrojejunostomy on Oct. 23, 1957)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
None.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ alive on January 19, 1958 , and that death occurred at 3:30 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 119 North Potomac St. DATE SIGNED 1-20-58	
ACTUAL SIGNATURE <i>R. A. Bell</i>		M.D.	
PHYSICIAN'S NAME (Type) R. A. Bell, M. D.		Hagerstown, Maryland.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
22d. LOCATION (City, town, or county) Hagerstown, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR JUN 22 '58
			24b. REGISTRAR'S SIGNATURE <i>DeLoach</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

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BUREAU V. S.

AN 1958

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